KEMENTERIAN KESEHATAN REPUBLIK INDONESIA

PROGRAM STUDI DIPLOMA TIGA
REKAM MEDIS DAN IFORMASI KESEHATAN
POLTEKKES KEMENKES YOGYAKARTA
KEMENTRIAN KESEHATAN REPUBLIK INDONESIA

DEPARTMENT OF HOSPITALS

MODUL 1

Pengantar : Departement of Hospitals

Kode Mata Kuliah : RMIK103

Tanggal Mulai : 23 Januari 2022

Departement of Hospitals

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Muhammad Irfan Fatoni

I. HOSPITAL UNITS

Hospitals have different types of units which provide different types of care and services for patients. Hospital units can be separated into two categories based on the level (or acuity) of care they provide.

a. Intensive Care Units

Intensive care units (ICUs) are areas of the hospital where seriously ill patients receive specialized care such as intensive monitoring and advanced life support. These units are also called critical care units, intensive therapy units, or intensive treatment units. Some common kinds of intensive care units are:

- Neonatal intensive care units (NICUs) which provide care for newborn infants
- Pediatric intensive care units (PICUs) which provide care for children

- Coronary care and cardiothoracic units (CCUs/CTUs) which provide care for heart attack or heart surgery patients
- Surgical intensive care units (SICUs) which provide care for other surgical patients • Medical intensive care units (MICUs) which provide care for patients with medical conditions who do not require surgery
- Long term intensive care units (LTAC ICUs) which provide care for prolonged critical care needs patients **b. Non-Intensive Care Units**

Non-Intensive Care Units often make up the majority of beds in a hospital and provide a lower level of care. These units may also be called wards. Some common kinds of non-ICU units are:

- Neonatal units which provide care for ill premature infants and neonates
- Women and infant health units which provide care before, during and after childbirth (perinatal) for mothers and for well newborn babies
- Pediatric units which provide care for children younger than 19 years old
- Post-critical care (or step down) units which care for patients no longer needing ICU level care
- Oncology units which provide care for patients with cancer and immune system disorders
- Surgical units which provide care for pre- and post-surgical patients, and/or which may specialize in certain types of surgery (like orthopedic joint surgery)

- Medical units which provide care for conditions like stroke, heart attack, or pneumonia
- Rehabilitation wards which provide care to improve mental or physical function after injury, trauma, stroke, or other acute neurologic condition
- Long-term care wards which provide care to patients for an extended period of time

2. The Names of the Wards in the Hospital

a. Surgical ward
b. Medical ward
c. Orthopedic ward

d. Gynecological ward
e. Pediatric ward
f. Dermatological Ward
g. Dental ward

3. Asking the security about the ward (Bertanya pada satpam tentang ruang rawat) Woman :

Excuse me. Can you help me, please?

Security : What can I do for you?

Woman : I want to go to the ward room number 404. But I can't find it.

Security : The ward is in the 4th floor, Ma'am. The room you're looking for is the fourth room from the elevator.

Woman: How can I get to the 4th floor? Can I use the elevator?

Security: You can take the stairs or the elevator for visitor.

Woman: Alright. Thank you.

Security: You're welcome.

6. assignment 1

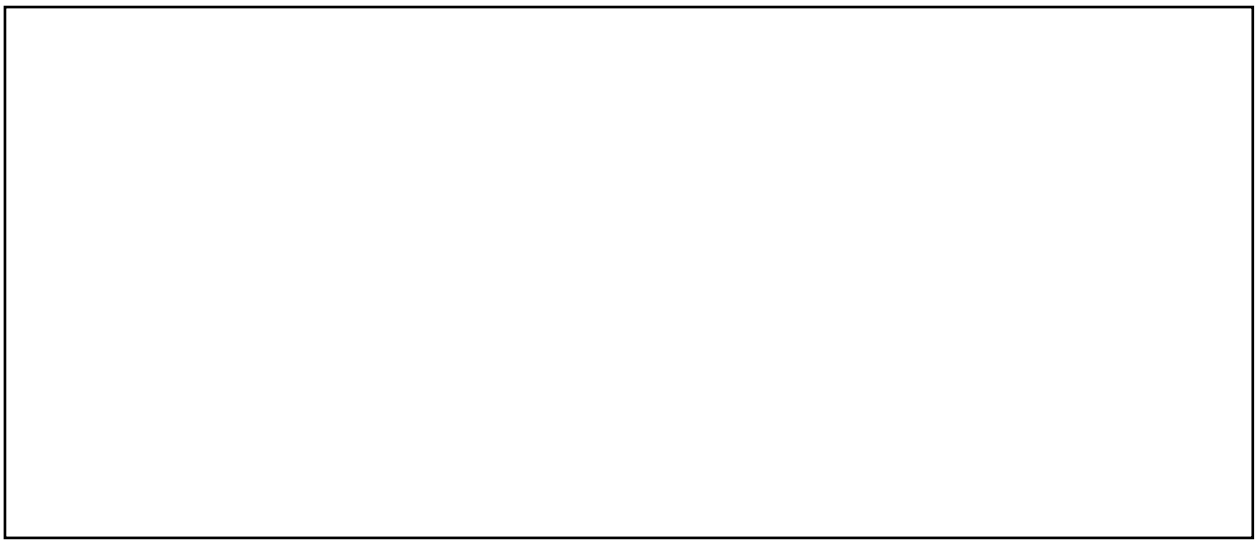
a. task 1 students make a dialogue about asking the wards in the hospital

b. Task 2

Look for the words that belong to the hospital ward below

on vacation I went to hospital x to visit one of my uncle's children. I went with my father and mother by car. The first things I saw were the patient registration room and the emergency room. Then my father came to the patient registration area to ask about the orchid room. It turns out that there are many clinic rooms in it such as dental treatment rooms, inpatient rooms, outpatient rooms. While climbing the stairs I also saw the operating room, orthopedic

room and others which were on the 1st floor. After arriving at the room where my uncle's son was, namely Orchid Room 1, to be precise in the pediatric intensive care unit.



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THE MOST COMMON MEDICAL TERMINOLOGY

MODUL 2

Pengantar : The Most Common Medical Terminology

Kode Mata Kuliah : RMIK103

Tanggal Mulai : 23 Januari

COMMON MEDICAL TERMINOLOGY LIST

Basic Medical Terminology

Most medical terms consist of three basic components: the root word (the base of the term), prefixes (in front of the root word), and suffixes (at the end of the root word). When combined, you can define a specific medical term. For example, the word “neuroblastoma” can be broken down this way:

“Neuro” - nerves

+

“Blast” - immature cell development

+

“Oma” - a cyst or tumor

Almost every medical term consists of root words and likely uses prefixes (at the beginning) and/or suffixes (at the end) to modify the end result. Some of the most common roots include:

CARCIN/O	cancer	carcinogenic = cancer causing
CARDI/O	heart	pericarditis = heart inflammation
CYTO-	cell	cytotoxic = toxic to the cell

Medical Prefixes

CARCIN/O	cancer	carcinogenic = cancer causing
DERMA-	skin	dermatitis = inflammation of the skin
GASTRO	stomach/abdomen	Gastroenteritis = inflammation of the stomach and intestines
GYNE/O	female	Gynecology = branch of medicine related to the female reproductive system
HISTIO-	tissue	histology = study of tissue
HEPATI-	liver	hepatoblastoma = liver cancer
MALIGN-	bad / harmful	malignant = growing, spreading
NEPHRO-	kidney	nephrotoxic = harmful to the kidneys
NEURO-	nerves	neuroblast = an immature nerve cell
ONCO-	mass / tumor	oncology = the study of cancer
OSTEO-	bone / bony tissue	osteosarcoma = bone cancer

Prefixes change the meaning of the original word: A prefix (in front of a word) can put an unknown word into perspective. For example, if a word begins with “aden-” or “adeno-”, it should always relate to the glands.

The Most Common Medical Prefixes :

Ab-	Away from
Ad-	Toward
Bi-	Two; double
Brachio-	Arm

Chemo-	Chemical
Co-, con-, com-	Together; with
De-	Down; from
Di-	Twice; two
Dia-	Throughout
Ecto-	Outside
Encephal/o	Brain
Hemi-	Half; half of
Hemat/o-	Blood
Hyper-	Above; excessive; beyond
Hyp-, Hypo-	Below; beneath; deficient

Medical Suffixes

Studying medical suffixes is great because there are a lot fewer to memorize than prefixes! Medical suffixes typically indicate whether the word is a procedure, disease, condition, or part of speech (e.g. verb, noun, adjective). For example, if you hear the word "adenocarcinoma", the "oma" will inform you that a tumor is present. In this case, a cancerous tumor. Some common medical suffixe**s** include:

-ary	Pertaining to
-ase	Enzyme
-ation	Process
-cele	Hernia

-clasis	To break
-dilation	To expand; stretch
-dynia	Pain; discomfort
-ectomy	Removal
-edema	Swelling; inflammation
-genesis	To form
-globin	Protein
-graphy	Recording of something
-ia	Condition
-icle	Small, possibly microscopic
-itis	Swelling; inflammation
-lysis	Breakdown; deterioration; separation
-mania	Obsession
-mortem	Death

Chapter 1

Choose the answer (in the right column) for the questions in the left column :

1. Aden/o	( )	A. Tongue
2. Bronch/o	( )	B. Eye
3. Cheil/o	( )	C. Lip
4. Derm/o	( )	D. Brain
5. Encephal/o	( )	E. Nose

6. Gloss/o	( )	F. Air
7. Rhin/o	( )	G. Bronchus
8. Irid/o	( )	H. Gland
9. Aero	( )	I. Skin
10. Thorac/o	( )	J. Chest

Chapter 2

Analyze the terms below by mentioning root, prefixes, and suffixes and complete with the meaning of these terms

1. Endocarditis :
2. Rhinorrhea :
3. Osteotomy :
4. Myorrhexis :
5. Myelomata :

Source: https://aimseducation.edu/blog/all-essential-medical-terms

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DEPARTMENT OF HOSPITALS

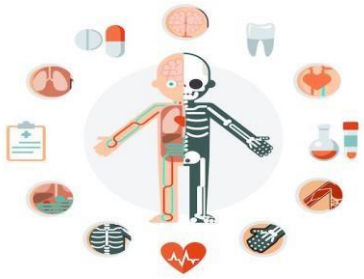
MODUL 3

Pengantar : Departement of Hospitals

Kode Mata Kuliah : RMIK103

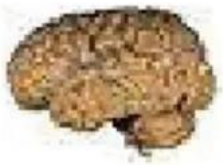
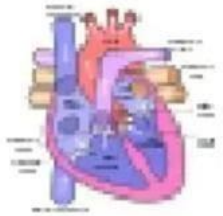
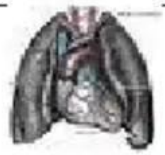
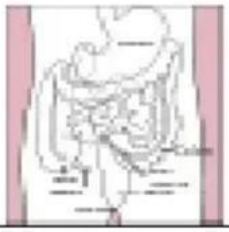
Tanggal Mulai : 23 Januari 2022

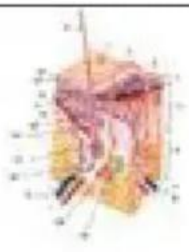
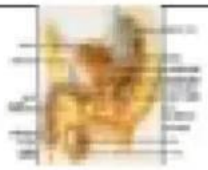
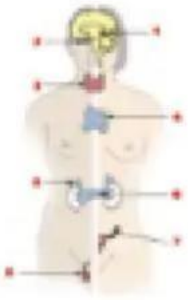
PARTS OF BODY



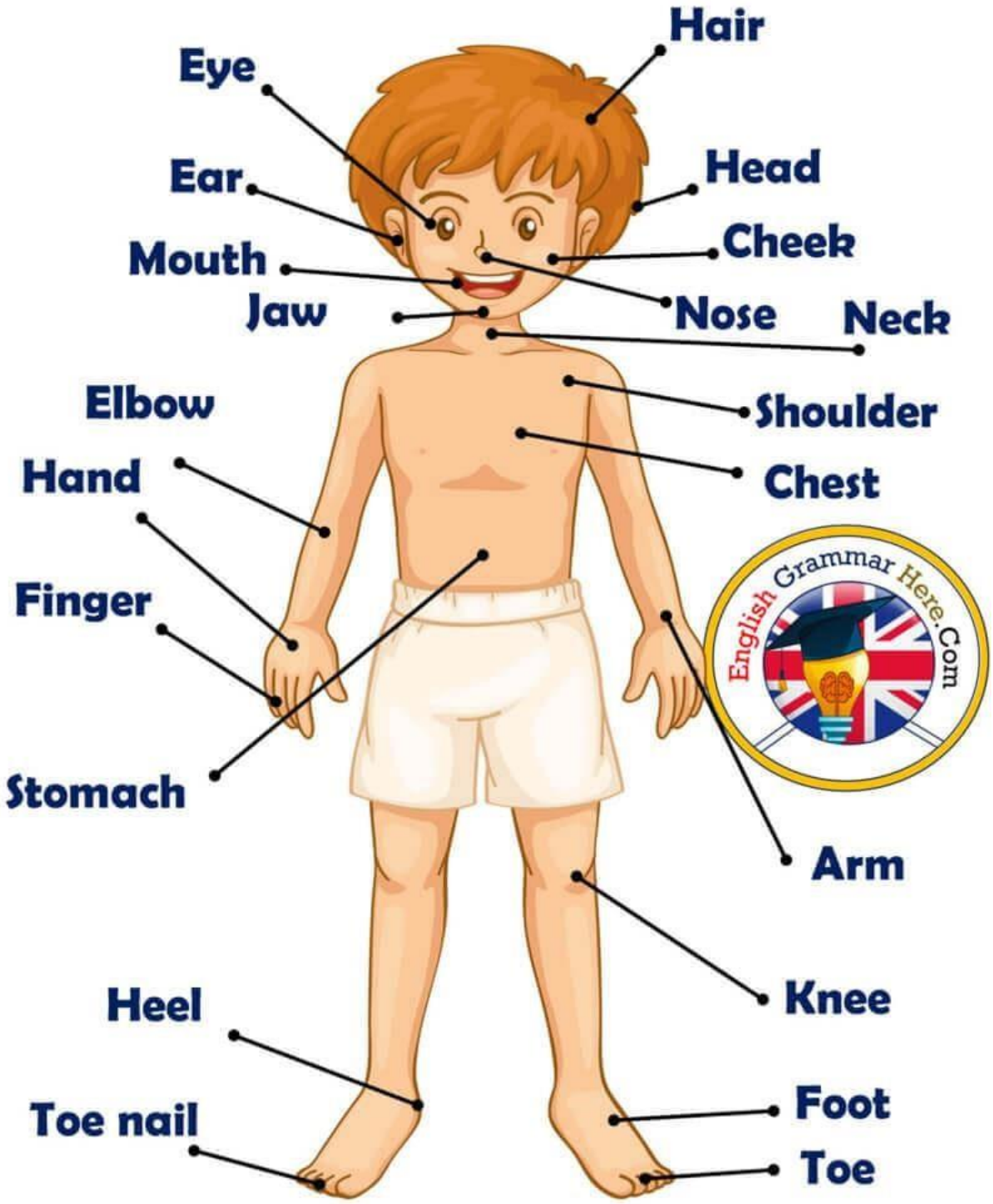
The human body consists of many interacting systems. Each systemcontributes to the maintenance of homeostasis, of itself, other systems, andthe entire body. A system consists of organs, which are functional collections of tissue. Systems do not work in isolation, and the well-being of the persondepends upon the well-being of all the interacting body systems

1. Parts of body function

No		System
1		The nervous system consists of the central nervous system (the brain and spinal cord) and the peripheral nervous system. The brain is the organ of thought, emotion, memory, and sensory processing, and serves many aspects of communication and controls various systems and functions. The special senses consist of vision, hearing, taste, and smell. The eyes, ears, tongue, and nose gather information about the body's environment.
2		The musculoskeletal system consists of the human skeleton (which includes bones, ligaments, tendons, and cartilage) and attached muscles. It gives the body basic structure and the ability for movement. In addition to their structural role, the larger bones in the body contain bone marrow, the site of production of blood cells. Also, all bones are major storage sites for calcium and phosphate. This system can be split up into the muscular system and the skeletal system.
3		The circulatory system or cardiovascular system comprises the heart and blood vessels (arteries, veins, and capillaries). The heart propels the circulation of the blood, which serves as a "transportation system" to transfer oxygen, fuel, nutrients, waste products, immune cells, and signalling molecules (i.e., hormones) from one part of the body to another. The blood consists of fluid that carries cells in the circulation, including some that move from tissue to blood vessels and back, as well as the spleen and bone marrow.
4		The respiratory system consists of the nose, nasopharynx, trachea, and lungs. It brings oxygen from the air and excretes carbon dioxide and water back into the air.
5		The gastrointestinal system consists of the mouth, esophagus, stomach, gut (small and large intestines), and rectum, as well as the liver, pancreas, gallbladder, and salivary glands. It converts food into small, nutritional, non-toxic molecules for distribution by the circulation to all tissues of the body, and excretes the

		unused residue. Sometimes also called the digestive system.
6		The integumentary system consists of the covering of the body (the skin), including hair and nails as well as other functionally important structures such as the sweat glands and sebaceous glands. The skin provides containment, structure, and protection for other organs, but it also serves as a major sensory interface with the outside world.
7		The urinary system consists of the kidneys, ureters, bladder, and urethra. It removes water from the blood to produce urine, which carries a variety of waste molecules and excess ions and water out of the body.
8		The reproductive system consists of the gonads and the internal and external sex organs. The reproductive system produces gametes in each sex, a mechanism for their combination, and a nurturing environment for the first 9 months of development of the infant.
9		The immune system consists of the white blood cells, the thymus, lymph nodes and lymph channels, which are also part of the lymphatic system. The immune system provides a mechanism for the body to distinguish its own cells and tissues from alien cells and substances and to neutralize or destroy the latter by using specialized proteins such as antibodies, cytokines, and toll-like receptors, among many others.
10		The main function of the lymphatic system is to extract, transport and metabolize lymph, the fluid found in between cells. The lymphatic system is very similar to the circulatory system in terms of both its structure and its most basic function (to carry a body fluid).
11		The endocrine system consists of the principal endocrine glands: the pituitary, thyroid, adrenals, pancreas, parathyroids, and gonads, but nearly all organs and tissues produce specific endocrine hormones as well. The endocrine hormones serve as signals from one body system to another regarding an enormous array of conditions, and resulting in variety of changes of function. There is also the exocrine system.

The Human Body



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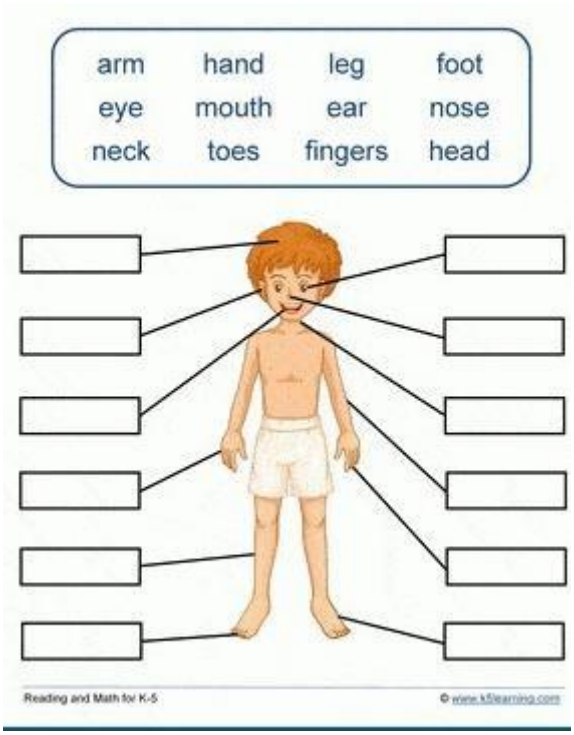
Task 1



Task 2

No	Organ	Function
1.	Brain	
2.	Heart	
3.	Liver	
4.	Stomach	
5.	Lung	

6.	Kidney	
7.	Intestines	
8.	Pancreas	
9.	Bladder	
10.	Anus	

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SIGNS AND SYMPTOMS OF THE DISEASE

MODUL 4

Pengantar : Signs and symptoms of the disease

Kode Mata Kuliah : RMIK103

Tanggal mulai : 31 Januari 2022

Signs and symptoms of the disease

Many people use the words ‘sign’ and ‘symptom’ interchangeably. However, there are important differences that affect their use in the field of medicine.

Any objective evidence of a disease, such as a skin rash or a cough, is a sign. A doctor, family members, and the individual experiencing the signs can identify these.

However, less obvious breaks in normal function, such as stomachache, lower back pain, and fatigue, are symptoms and can only be recognized by the person experiencing them. Symptoms are subjective, meaning that other people only know about them if informed by the individual with the condition.

This MNT Knowledge Center article will look at the implications of signs and symptoms as well as their history. The piece will also introduce the different types of sign and symptom and their uses in medicine.

Fast facts on signs and symptoms

1. A light headache can only ever be a symptom because no one else can observe it.
2. Medical symptoms are split into chronic, relapsing, and remitting.
3. An example of a medical sign is high blood pressure, as it can be measured and observed by another person.
4. Anthony van Leuwenhoek invented the microscope in 1674, forever changing the face of diagnostic tools.

The key difference between signs and symptoms is who observes the effect.

For example, a rash could be a sign, a symptom, or both:

1. If the patient notices the rash, it is a symptom.
2. If the doctor, nurse, or anyone other than the patient notices the rash, it is a sign.
3. If both the patient and doctor notice the rash, it can be classed as both a sign and a symptom.

Regardless of who notices that a system or body part is not functioning normally, signs and symptoms are the body's ways of letting a person know that not everything is running smoothly. Some signs and symptoms need follow-up by a medical professional, while others may completely resolve without treatment.

Example

Flu Symptoms

Influenza (flu) can cause mild to severe illness, and at times can lead to death. Flu is different from a cold. Flu usually comes on suddenly. People who have flu often feel some or all of these symptoms:

- fever* or feeling feverish/chills
- cough
- sore throat
- runny or stuffy nose
- muscle or body aches
- headaches
- fatigue (tiredness)
- some people may have vomiting and diarrhea, though this is more common in children than adults.

*It's important to note that not everyone with flu will have a fever.

Flu Complications

Most people who get flu will recover in a few days to less than two weeks, but some people will develop complications (such as pneumonia) as a result of flu, some of which can be lifethreatening and result in death.

Sinus and ear infections are examples of moderate complications from flu, while pneumonia is a serious flu complication that can result from either influenza virus infection alone or from co-infection of flu virus and bacteria. Other possible serious complications triggered by flu can include inflammation of the heart (myocarditis), brain (encephalitis) or muscle (myositis, rhabdomyolysis) tissues, and multi-organ failure (for example, respiratory and kidney failure). Flu virus infection of the respiratory tract can trigger an extreme inflammatory response in the body and can lead to sepsis, the body's life-threatening response to infection. Flu also can make chronic medical problems worse. For example, people with asthma may experience asthma

attacks while they have flu, and people with chronic heart disease may experience a worsening of this condition triggered by flu.

Assignment 1

find the name of the disease accompanied by the symptoms

Assgment 2

Fill in the name of the disease according to the definition

No	Definition	Desease
1.	inflamation or infection of the lungs in which air sacs fill with pus. It causes chest pain and coughing	
2.	A disease in which the pancreas fails to produceenough insulin	
3.	A malignant tumor anywhere in the body is caused by uncontrolled cell division	

4.	A mild but contagious children's disease, it's accompanied by a skin rash	
5.	Sudden paralysis (usually on one side of the body)caused by interruption of blood flow to the brain	
6.	From the mental illness in which the person loses thedesire to eat, causing severe weight loss (especiallyamong adolescent females)	
7.	A week condition is caused by not enough red bloodcells in the body or by loss of blood	
8.	A disease that is caused chills, fever and sweating, itis transmitted by the bite of the anopheles mosquito	
9.	Inflammation of the tonsils, causing sore throat andfever	
10	Severe weakening or destruction of the body's immune system by the human immune deficiencyvirus	

https://www.medicalnewstoday.com/articles/161858

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PATIENT ASSESSMENT RECORDS AND DISCHARGE SUMMARY

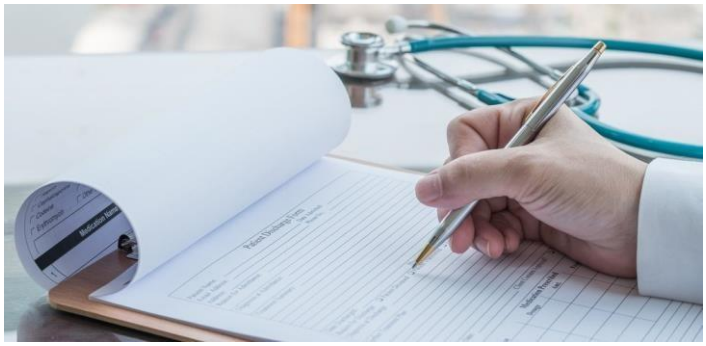
MODUL 5

Pengantar : Patient Assessment Records and Discharge Summary

Kode Mata Kuliah : RMIK103

Tanggal Mulai : 23 Januari

HOW TO WRITE A DISCHARGE SUMMARY



A. Patient Discharge Summary

A discharge summary is a handover document that explains to any other healthcare professional why the patient was admitted, what has happened to them in hospital, and all the information that they need to pick up the care of that patient quickly and effectively. The document is produced during a patient's stay in hospital as either an admitted or non-admitted patient, and issued when or after the patient leaves the care of the hospital. It is often the primary mode of communication between the hospital care team and aftercare providers. It is considered a legal document and it has the potential to jeopardize the patient's care if errors are made. Delays in the completion of the discharge summary are associated with higher rates of readmission, highlighting the importance of successful transmission of this document in a timely fashion.

In practice, each summary is adapted to the clinical context. As such, not all information included in this guide is relevant and needs to be mentioned in each discharge summary. In addition, different hospitals have different criteria to be included and you should always follow your hospital's or medical school's guidelines for documentation.

Patient Details

Important information to include regarding the patient includes :

1. Patient name : Full name of the patient (also the patient's preferred name if relevant) 2. Date of birth

3. Unique identification number
4. Patient address : the usual place of residence of the patient
5. Patient telephone number
6. Patient sex : sex at birth (this determines how the individual will be treated clinically)
7. Gender : the gender the patient identifies with
8. Ethnicity : ethnicity as specified by the patient
9. Next of kin/emergency contact : full name, relationship to the patient and contact details

GP Details

This section should be completed with the details of the General Practitioner with whom the patient is registered :

1. GP name : the patient's usual GP
2. GP Practice details : name, address, email, telephone number and fax of the patient's registered GP practice
3. GP Practice identifier : a national code which identifies the practice

Hospital Details

This section should encompass the salient aspects of the patient's discharge :

1. Discharging consultant : the consultant responsible for the patient at the time of discharge
2. Discharging specialty/department : the specialty/department responsible for the patient at the time of discharge
3. Date and time of admission and discharge
4. Discharge destination : destination of the patient on discharge from hospital (e.g. home, residential care home)

Clinical Details

Include a focused summary of the patient's presenting symptoms and signs:

Example :

"Mrs Smith presented to A&E with worsening shortness of breath and ankle swelling. On arrival, she was tachypnoeic and hypoxic (oxygen saturation 82% on air). Clinical examination revealed reduced breath sounds and dullness to percussion in both lung bases. There was also a significant degree of lower limb oedema extending up to the mid-thigh bilaterally."

Diagnoses

This section should include the diagnosis or diagnoses that were made during the patient's stay in hospital :

"Mrs Smith was reviewed by the Cardiology team who confirmed a diagnosis of congestive heart failure."

If no diagnosis was confirmed, use the presenting complaint and explain no cause was identified :

"No clear cause was identified for the patient's chest pain at this time."

Be as specific as possible when documenting diagnoses. Some examples of diagnoses for which you should include specific details include:

- Diabetes: type 1, type 2, steroid-induced, gestational
- Myocardial infarction: NSTEMI, STEMI
- Pneumonia: bacterial, viral, aspiration pneumonia
- Septicaemia: causative organism and source (e.g. E.Coli urosepsis)
- Gastroenteritis: viral, bacterial

Future Management

Include details of the current plan to manage the patient and their condition(s) after discharge from hospital :

- Treatments (e.g. medication, surgery, etc)
- Hospital follow up
- Referrals made by the hospital (e.g. referral to chronic pain team)
- Example: "We have discharged Mrs Smith on regular oral Furosemide (40mg OD) and we have requested an outpatient ultrasound of her renal tract which will be performed in the next few weeks. We will review Mrs Smith in the Cardiology Outpatient Clinic in 6 weeks time. After review from our social worker and occupational therapist, we have arranged a once-daily care package to assist Mrs Smith with her activities of daily living."

Person Completing Record

This section includes personal information about the healthcare provider completing the discharge summary:

- Name
- Designation or role
- Grade
- Specialty
- Date completed

B. Patient Assessment Record Example :

Name: Ethel Patridge	**Whom to contact in emergency:** **Parents and** Robert Greene	**MEDICAL INFORMATION** **Relevant medical history:** Nil
Prefers to be addressed as: Effie	**Reason for admission:** Became unscious after feeling unwell & increasingly drowsy	Medical diagnosis: Diabetic ketoacidosis Allergies: Elastoplast
Address: 33 Madison Way, Lower Stockton	**Petient's understanding of admission:** Unconsciousness on admission	Patient's feelings and expectations related to present illness: Unable to assess due to unconsciousness
Other persons important to patient: Robert Greene (live in partner)	**Source of assessment:** Partner	**Nurse's initial impression (physical and social):** Physically fit, well-adjusted young woman with lots of friends
DOB: 12.3.75 **Telp. :** 01765 342189 **Doctor:** Dr. Sullivan **Primary nurse:** Jean Bradshaw	**Family understanding of admission:** Understanding diabetes	**Knowledge/information skills needed for continued self-care after discharge:** 1. Diabetes and how it affect the body 2. Insulin therapy and self-administration 3. Factors effecting body's need for glocuse

Chapter 1 :

Create a patient discharge summary

Chapter 2 :

Complete the Paul Marstan Patient Assessment form below by selecting A, B, and C for each point. choose the most appropriate :

PATIENT ASSESSMENT RECORD

Patient's Name:
Paul Marston

Prefers to be addressed as:
Paul

Reason for admission:

a. Involved in road accident.
b. Lacerated forehead, headache + PTA 2 min.
c. Minor head injury, unconscious approx. 2 min,

Answer: ….

Family's understanding of admission:

Injured in accident

Nurse's initial impression (physical and social):

a. Patient active, alert, no apparent problems besides injury.
b. Patient disorientated but not traumatised.
c. Patient active and alert, no signs of any kind of injury.

Answer: ….

Patient's understanding of admission:

a. Fell of bike, cut on head.
b. Confused about accident.
c. Feeling sick.

Answer: ….

Medical diagnosis:

a. Lacerated head with PTA of poss. 15 min.
b. Injured head. Poss. PTA 15 min.
c. Poss. Injury to head with 15 min PTA.

Answer: ….

Source: https://geekymedics.com/how-to-write-a-discharge-summary/

https://id.scribd.com/document/371395351/2-Modul-Mahasiswa-Bing-2-Fix-1

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PROCEDURE FOR FILING OUT MEDICAL RECORD FORMS

MODUL 6

Pengantar : Procedure for Filling out Medical Record Forms

Kode Mata Kuliah : RMIK103

Tanggal mulai : 23 Januari

Procedure for filling out medical record forms

A medical record is a systematic documentation of a patient's medical history and care. It usually contains the patient's health information (PHI) which includes identification information, health history, medical examination findings and billing information.

Medical records traditionally were kept in paper form, with tabs separating the sections. As printed reports were generated, they were moved to the correct tab. With the advent of the electronic patient record, these sections may still be found but as tabs or menus within the electronic record.

1. Patient Demographics:

Face sheet, Registration form
Patient Name
Address and phone numbers (home and mobile)
Email address
Sex, Age, Birthday, and Race (Ethnicity)
Occupation and Employer name, address, and phone number Spouse Name and contact information in case of emergency contact

2. Financial Information:

Insurance payer name, address and phone number
Subscriber name
Policy number
Responsible party name, address and phone number
Responsible party employer, occupation and employer phone number Patient relationship to the insured

3. Consent and Authorization Forms:

Consent for treatment: For any course of treatment that is above routine medical procedures, the physician must disclose as much information as possible so the patient may make an informed decision about his/her care. This information should include:

Diagnosis and chances of recovery
Recommended course of treatment
Risks and benefits involved in treatment
Risks if no treatment is taken
Probability of success if treatment is taken
Recovery challenges and length of time
Assignment of benefits: the patient or guarantor authorizes their health insurance company to make payments directly to the physician, medical practice or hospital for the treatment received.

4. Release of information:

A valid authorization to release protected health information includes:

Identity verification such as a driver's license.
A description of the information to be used or disclosed.
The name of the person or organization authorized to disclose the information. The name of the person or organization that the information is to disclosed. Signature of the person authorized to release the information.

5. Treatment History:

Chief complaints
History of illness
Vital signs
Physical examination
Surgical history
Obstetric history
Medical allergies
Family history
Immunization history
Habits such as exercise, diet, alcohol intake, smoking, and drug use/abuse Developmental history

6. Progress Notes:

Progress notes include new information and changes during patient treatment. They are written by all members of the patient's treatment team. Some of the information included in progress notes includes:

Observations of the patient's physical and mental condition

Sudden changes in the patient's condition
Vital signs at certain intervals
Food intake
Bladder and bowel functions

7. Physician's Orders and Prescriptions:

Physician's orders for the patient to receive testing, procedures or surgery including directions to other members of the treatment team. Prescriptions for medications and medical supplies or equipment for the patients home use.

Consults: Findings opinions from consulting physicians. Lab Reports:
Record of findings from lab testing.

8. Radiology Reports:

Record of findings from radiology testing.

9. Nursing Notes:

Nurse's notes include documentation separate from the physician including:
Patient assessment
Processes
Intervention Evaluation

10. Medication List:

Prescription and nonprescription medication including dose, method of intake, and schedule.

11. HIPAA Notice of Privacy Practices:

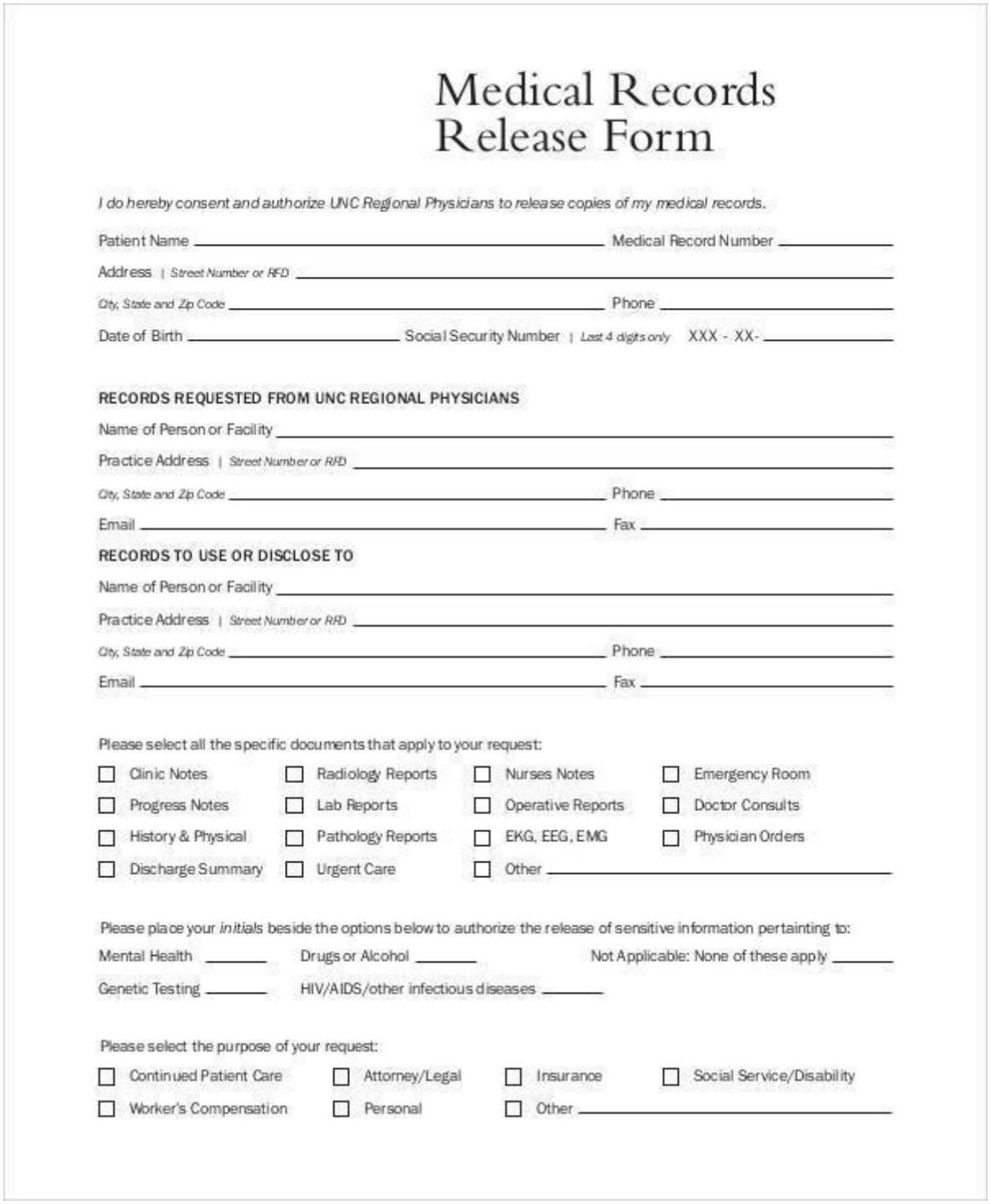
This notice, as required by the HIPAA Privacy Rule, gives patients the right to be informed about their privacy rights as it relates to their protected health information (PHI).

12. Patient Confidentiality:

Each medical office has a responsibility to their patients by federal law to keep their personal health information private and secure. Disclosures made regarding a patient's protected health information without their authorization is considered a violation of the Privacy Rule under HIPAA. Most privacy breaches are not due to malicious intent but are accidental or negligent on the part of the organization.

Develop a formal security management process including the development of policies and procedures, internal audits, contingency plan and other safeguards to ensure compliance by medical office staff.
Develop policies for verifying access authorizations, equipment control, and handling visitors.
Develop and provide documentation including instructions on how your medical office can help to protect PHI (for example, logging off the computer before leaving it unattended).
Establish unique user identification including passwords and pin numbers.

A. sample medical record form



Medical Records Release Form

I do hereby consent and authorize UNC Regional Physicians to release copies of my medical records.

Patient Name _____ Medical Record Number _____

Address | *Street Number or RFD* _____

City, State and Zip Code _____ Phone _____

Date of Birth _____ Social Security Number | *Last 4 digits only* XXX - XX- _____

RECORDS REQUESTED FROM UNC REGIONAL PHYSICIANS

Name of Person or Facility _____

Practice Address | *Street Number or RFD* _____

City, State and Zip Code _____ Phone _____

Email _____ Fax _____

RECORDS TO USE OR DISCLOSE TO

Name of Person or Facility _____

Practice Address | *Street Number or RFD* _____

City, State and Zip Code _____ Phone _____

Email _____ Fax _____

Please select all the specific documents that apply to your request:

☐ Clinic Notes	☐ Radiology Reports	☐ Nurses Notes	☐ Emergency Room
☐ Progress Notes	☐ Lab Reports	☐ Operative Reports	☐ Doctor Consults
☐ History & Physical	☐ Pathology Reports	☐ EKG, EEG, EMG	☐ Physician Orders
☐ Discharge Summary	☐ Urgent Care	☐ Other _____	

Please place your *initials* beside the options below to authorize the release of sensitive information pertainting to:

Mental Health _____ Drugs or Alcohol _____ Not Applicable: None of these apply _____

Genetic Testing _____ HIV/AIDS/other infectious diseases _____

Please select the purpose of your request:

☐ Continued Patient Care	☐ Attorney/Legal	☐ Insurance	☐ Social Service/Disability
☐ Worker's Compensation	☐ Personal	☐ Other _____	

Task 1

Look for the medical record form and fill it out

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MEDICAL RECORDS

MODUL 7

Pengantar : Medical Records

Kode Mata Kuliah : RMIK103

Tanggal Mulai : 31 Januari 2022

Medical Records

A. medical record meaning

Medical Record or what we call it in Indonesia. Medical record is a record or record containing who, what, why, when, where, and how the services provided to patients during the treatment period contain sufficient information to identify the patient, establish a diagnosis and treatment and record the results.

The uses of medical records include:

1. Administration: It can be said that a medical record has administrative value, because it is evidence of cooperation as well as a means of communication between health workers who provide services to patients.
2. Legal: Legal, meaning that information in medical records can be used as a basis for legal evidence, such as allegations of malpractice, post-mortem examination et repertum and so on.
3. Finance: In terms of excellence, medical records can be the basis for determining the costs charged to patients.
4. Research Data in medical records is often used as a reference for research, especially those concerning health.
5. Education: In the field of education, data in medical records serves as a means of information transfer.
6. Documentation: In the aspect of documentation, it means that medical records become memory material that must be stored.

B. Medical Record Administration Data

1. Full name of the patient receiving treatment.
2. Medical record number and other identification numbers.
3. Full address where the patient currently resides.
4. Date, month, year, and city of birth of the patient receiving treatment.
5. Gender of the patient.

C. **Medical record activities 1. Assembling**

What is meant by assembling is the assembly of medical record documents/files by analyzing the completeness of the medical record files.

2. Coding and Indexing

Coding is looking for codes based on disease diagnoses according to the applicable disease classification, namely the book international statistical classification of diseases and related health problems (ICD-10 revision 10). reporting.

3. Filling

The filling section as the name implies, the main activity in this section is to store data and record medical data of a patient. In addition, it receives RM documents from coding/indexing affairs and stores it based on the terminal digit filling method sequentially.

Task 1

write completely the contents of the medical record form

Task 2

1. Name and describe the activities of the medical recorder
2. Is the medical record important please explain

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COMMUNICATION WITH PATIENTS

MODUL 8

Pengantar : Communication With Patients

Kode Mata Kuliah : RMIK103

Tanggal Mulai : 23 Januari

COMMUNICATING EFECTIVELY WITH PATIENT AND FAMILIES

Communication with Patients

Communicating effectively with patients and families is a cornerstone of providing quality health care. The manner in which a health care providercommunicates information to a patient can be equally as important as theinformation being conveyed. Patients who understand their providers are morelikely to accept their health problems, understand their treatment options, modifytheir behavior and adhere to follow-up instructions. If the single most importantcriterion by which patients judge us is by the way we interact with them, it standsto reason that effective communication is at the core of providing patient-centeredcare. Patient surveys have demonstrated when communication is lacking, it is palpably felt and can lead to patients feeling increased anxiety, vulnerability and powerlessness.

Read the texts bellow carefully!

The Patient Perspective:

“On the unit in particular, I don’t remember being called by my name in the sixdays I was there. They asked me what name I would like to be called and I toldthem but they didn’t use it.” *

“I felt like I was interrupting them when I asked for help.” *

“There was one nurse who was really rude. I had an epidural and I couldn’t feelmy legs so I got scared, but this other nurse just said, „Relax and enjoy that your pain is relieved.” *

“I was treated badly by a nurse. I would have wanted to complain, but there is no way to do that. You don’t want to jeopardize your care. It would be nice if therewas a way to get the message across that this nurse needs some attention for her behavior.” *

“As for the documentation in checking me in, it took them several hours to check me into my room. But I was okay with that because they told me what was goingon and that ten other patients had come in at the same time, which I totally understood. When you’re in a situation like that the communication is what soothes you. Not knowing scares you more.”

The Staff Perspective:

“The niceness of the nurses really has an impact. The happier they are, the more it feeds on itself.”

*

“Having patients know that we want them to ask us questions, and that we are receptive and responsive to the questions, helps us build stronger relations with our patients.”

The Leadership Perspective:

“On the one hand, we need to treat [patients] as partners, and as intelligent, and somebody who we need to engage in a positive way, but we also have torecognize that the environment that we are placing them in is very foreign tothem, and it is creating feelings of helplessness, fear and anxiety. And we're not really being responsive to that.” (Patrick Charmel, Griffin Hospital).*

“…how do we [communicate to] patients…that they can open up to the front line caregivers, they can question things, they can ask questions, that they have the right to expect this type of personalized attention?” (Raymond Troiano, M.D.,Sentara Virginia Beach General Hospital)

Communicating health care information is difficult. The concepts arecomplex and emotional. However, establishing a connection from the onsetenables patients to open up, be somewhat less frightened and concentrate on what is really important—the information you are providing. Special care and sensitivity is also in order when communicating with a patient or family member who has a complaint about their care. The ClevelandClinic uses the acronym H.E.A.R.T. to describe how staff members are expectedto respond to patient and family complaints and/or concerns.

Hear the Story

Emphatize

Apologize

Respond to the problem
Thank them

To keep this important approach to handling sometimes difficult conversations top of mind, the hospital provide staff members with a badge, reminding them to “Respond with H.E.A.R.T”

1. Communication StandardsIn healthcare, where fears and anxieties are high, it is important to use phrasesthat are easily understood and convey our dedication to providing the highestquality healthcare.
2. Establish A ConnectionWhen we break down communication barriers with our patients and families,we create an environment of open dialogue and trust. By adopting thefollowing effective communication strategies, you will see the positiveimpact on patient satisfaction levels and the increased partnership thatmanifests between patient and caregiver.
3. Five Important Key Points In Delivering High Patient SatisfactionPatient Satisfaction Requires: C.P.R.
   C: Compassionate Communication
   P: Patient Information/Pain Management
   R: Response
   C.P.R Requires Consistent Delivery Of The Following:

a. Communicate to the patient who you are, what you do and who are themembers of the team.
b. Inform the patient daily what their plan is for the day and set expectations write on the whiteboard.
c. Inform the patient and family if they have any questions, concerns to call you are here to help.
d. Encourage the patient to communicate how we are doing in managingtheir pain their comfort is vital.
e. Include the patient tell them what you are doing in the room, even the simple things like adjusting IV's or taking a vital sign.The more you communicate about that you are doing, the more comfortable they will be with asking questions.

Chapter 1

Create a conversation between the patient and the health care provider, and then act out the conversation in the class.

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COMMUNICATION WITH PATIENTS

MODUL 9

Pengantar : Communication with patients

Kode Mata Kuliah : RMIK103

Communication with patients

Patient education allows patients to play a bigger role in their own care. It also aligns with the growing movement toward patient- and family-centered care.

To be effective, patient education needs to be more than instructions and information. Teachers and health care providers need to be able to assess patient needs and communicate clearly.

The success of patient education depends largely on how well you assess your patient's:

A. Needs
B. Concerns
C. Readiness to learn
D. Preferences
E. Support
F. Barriers and limitations (such as physical and mental capacity, and low health literacy or numeracy)

Often, the first step is to find out what the patient already knows. Use these guidelines to do a thorough assessment before starting patient education:

A. **Gather clues.** Talk to the health care team members and observe the patient. Be careful not to make assumptions. Patient teaching based on incorrect assumptions may not be

very effective and may take more time. Find out what the patient wants to know or take away from your meeting.

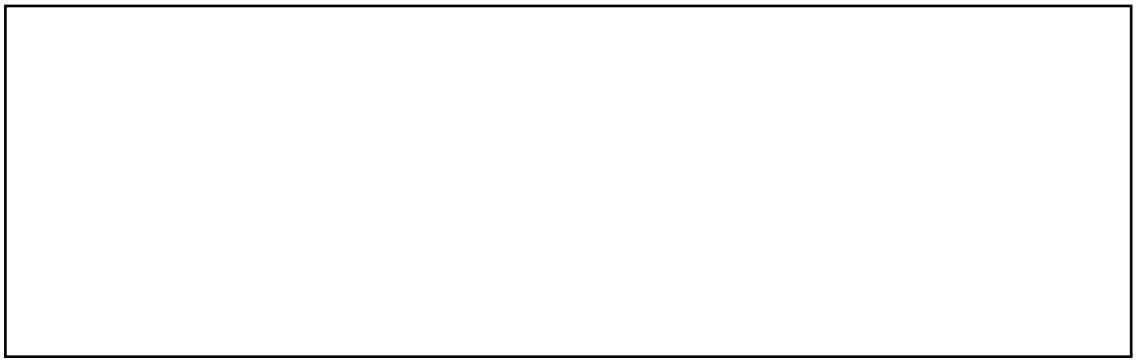
B. **Get to know your patient.** Introduce yourself and explain your role in your patient's care. Review their medical record and ask basic get-to-know-you questions.
C. **Establish a rapport.** Make eye contact when appropriate and help your patient feel comfortable with you. Pay attention to the person's concerns. Sit down near the patient.
D. **Gain trust.** Show respect and treat each person with compassion and without judgment.
E. **Determine your patient's readiness to learn.** Ask your patients about their outlooks, attitudes, and motivations.
F. **Learn the patient's perspective.** Talk to the patient about worries, fears, and possible misconceptions. The information you receive can help guide your patient teaching.
G. **Ask the right questions.** Ask if the patient has concerns, not just questions. Use openended questions that require the patient to reveal more details. Listen carefully. The patient's answers will help you learn the person's core beliefs. This will help you understand the patient's motivation and let you plan the best ways to teach.
H. **Learn about the patient's skills.** Find out what your patient already knows. You may want to use the teach-back• method (also called the show-me method or closing the loop) to figure out what the patient may have learned from other providers. The teachback method is a way to confirm that you have explained the information in a way that the patient they understand. Also, find out what skills the patient may still need to develop.
I. **Involve others.** Ask if the patient wants other people involved with the care process. It is possible that the person who volunteers to be involved in your patient's care may not be the person your patient prefers to be involved. Learn about the support available to your patient.
J. **Identify barriers and limitations.** You may perceive barriers to education, and the patient may confirm them. Some factors, such as low health literacy or numeracy may be more subtle and harder to recognize.
K. **Take time to establish rapport.** Do a comprehensive assessment. It is worth it, because your patient education efforts will be more effective.

Task 1

have a conversation between a medical officer or a health worker at the hospital

Task 2

make audio about the conversations that you have done in assignment 1 with your friends



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MEDICAL TERM, SYMBOL TO MEDICAL RECORDS FORM

MODUL 10

Pengantar : Medical term, symbol to medical records form

Kode mata kuliah : RMIK103

Tanggal mulai : 1 Januari 2022

medical term, symbol to medical records form

A. Patient Assessment

Patient assessment is the stage of the process where doctors, nurses, dietitians evaluate patient data both subjectively and objectively to make decisions regarding: a. Patient's health status

b. Care needs

c. Intervention

d. Evaluation

B. Patient Assessment Procedures A. Incident Reporting Flow to the Patient Safety Team at Hospital (Internal)

1. If an incident occurs (KNC/KTD/KTC/KPC) at hospital, must be followed up immediately (prevented/treated) to reduce the impact / unintended consequences.
2. After being followed up, immediately make an incident report by filling in the Incident Report Form at the end of the hour work/shift to the immediate supervisor (at the latest 2x24 hours); please don't delay the report.
3. After completing the report, immediately submit it to Reporting direct supervisor. (Direct supervisor agreed according to Management decisions: Supervisor/Head of Section/ Installation/Department/Unit).
4. The immediate supervisor will check the report and perform risk grading against reported incidents.
5. The results of the grading will determine the form of the investigation and The analysis will be carried out as follows:
   - Blue grade : Simple investigation by direct supervisor, maximum time of 1 week.
   - Green Grade : Simple investigation by direct supervisor, maximum time 2 weeks

- Yellow grade : Comprehensive investigation/Root analysis problem/RCA by the KP Team at the hospital, time maximum 45 days
- Red grade : Comprehensive investigation/Root analysis problem / RCA by the KP Team at the hospital, time maximum 45 days.

6. After completing a simple investigation, report the results of investigations and incident reports are reported to the KP Team in hospital.
7. The KP team at the hospital will re-analyze the results of the investigation and Incident report to determine whether it needs to be done further investigation (RCA) by regrading.
8. For grade Yellow/Red, the KP team at the hospital will do Root Cause Analysis (RCA)
9. After doing the RCA, the KP team at the hospital will make a report and Recommendations for improvement and "Learning" in the form of: Instructions / "Safety alert" to prevent the incident the same thing over and over again.
10. RCA results, recommendations and work plans are reported to Directors
11. Recommendations for "Improvement and Learning" given feedback to the relevant work units as well as socialization to all units in the hospital
12. The Work Unit analyzes events in its work unit each
13. Monitoring and Evaluation of Improvements by the KP Team at the Hospital.

C. Reporting Flow of Incidence Safety Committee hospital Patient (External)

Simple investigation report / root cause analysis / RCA that occurred in the patient and have received recommendations and solutions by the KP Team at the hospital (internal) / Hospital leadership sent to KKPRS by performing data entry (e-reporting) via KKPRS official website: www.buk.depkes.go.id

Symbols Used in *Patient Assessment Report*

1. Ψ (blue) is a symbol for allergies
2. ♀ is a symbol for patients with male gender
3. ♂ is a symbol for patients with female gender
4. ■ (black) is a symbol for patient who died
5. 0 is a symbol for infectious disease cases
6.)* is for patients with correct identity and social data
7.)# is for patients who claim to have come regularly and are registered by the registration officer with a new number
8. ↑ is a symbol for ascension
9. ↓ is a symbol for decline 10. = is the same symbol
11. ≠ is the symbol not equal
12. ° is the symbol for degree
13. # is a symbol for fracture

Provisions for giving symbols in cases of infectious diseases

a. Infectious diseases that must be given a symbol are cases of diseases, including:
   1) HIV or AIDS
   2) Hbs Ag Positive or Hepatitis B

3) Tuberculosis positive

b. Symbols for infectious disease cases are distinguished by color, namely:

1) HIV or AIDS : ● (red circle)
2) Hbs Ag positive or Hepatitis B : ● (blue circle)
3) Tuberculosis positive : ● (green circle)

Task 1

Abbreviation in Patient Assessment Report

Abreviations that can be used in hospitals is:
