PUPLIC AUTHORITY FOR APPLIEEDUCATION AND TRAINING
COLLEGE OF HEALTH SCIENCES
MEDICAL RECORDS TECHNICIAN PROGRAM
COURSE SYLLABUS

COURSE TITLE: INTRODUCTION TO THE MEDICAL RECORD FIELD

COURSE SYMBOLS AND NUMBER: M.R. 103

CREDITS: 2 (THEORY)

CONTACT HOURS: 2 PER WEEK FOR 15 WEEKS
PRE-REQUSITE: NONE
TYPE OF COURSE: PROFISSIONAL COMPULSORY

COURSE DISCRIPTION:

This Course is designed to introduce students to the field of medical records. The functions of the medical records department, the different medical record practitioners, and the various medical record forms are identified. Professional ethics are emphasized.

COURSE OBJECTIVES:

Upon successful completion of this course the student should be able to:

1. Define the medical record.
2. Trace the history of medical records, with special reference to Kuwait.
3. Discuss the value and uses of the medical record.
4. Name the major functions of the medical record department.
5. Distinguish between the different categories of medical record practitioners as regards qualifications and roles.
6. Demonstrate knowledge of the purpose and responsibility for completion of the various medical record forms.
7. Demonstrate commitment to professional ethics.

COURSE CONTENT:

I. Definition of the medical record
II. Historical development of medical records:
    A. World-wide
    B. In Kuwait
III. Value and uses of medical record:
    A. Uses of the medical record
    B. Vale of the medical record:
        1. The patient
        2. To health care providers
        3. To the health care facility
        4. To educators, researchers, and public health officials
IV. Functions and medical records department:
    A. Filling, storage, and retrieval of medical records

B. Registering, admitting, and discharging patients
C. Reviewing records for completion and accuracy
D. Coding
E. Compiling statistics
F. Maintenance of indexes and registers
G. Abstracting information from medical records
H. Typing medical records
I. Others

V. Medical Record Practitioners:
   A. Qualifications and roles for:
      1. Medical record administrator
      2. Medical record technician
      3. Auxilliary medical record personnel
   B. Professional ethics:
      1. Professionalism
      2. Ethical conduct
      3. Confidentiality of health information
      4. Patient's rights

VI. Flow of the medical record

VIII. Medical record forms:

   A. Classification of medical record data:
      1. Administrative
      2. Clinical: medical, nursing, and ancillary
   B. Content (in brief) and responsibility for completion of the following medical record forms:
      1. Unit summary sheet
      2. Admission summary sheet
      3. Authorization sheet.
      4. Referring letter sheet.
      5. Medical history sheet.
      6. Physical examination sheet.
      7. Physician's orders.
      8. Clinical progress notes.
      9. Anaesthesia report.
      10. Operation report.
      11. Consultation report.
      12. Laboratory reports.
      13. Nurses notes.
      14. Composite graphic chart.
      15. Fluid balance sheet.
      16. Nurses observation sheet.

ASSESSMENT:

1. Quizes 25%
2. Mid-term examination 25%
3. Final examination 50%

REQUIRED TEXTBOOKS:

1. Huffman, E. Medical Record Management. Berwyn, Illinois: Physicians Record Co. , 1985.

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MEDICAL RECORDS TECHNICIAN PROGRAM
COURSE SYLLABUS

COURSE TITLE: THE HEALTH CARE DELIVARY SYSTEM

COURSE SYMBOLS AND NUMBER: M.R. 104

CREDITS: 2 (THEORY)

HOURS: 2 PER WEEK FOR 15 CONTACT WEEKS

PRE-REQUSITE: NONE

TYPE OF COURSE: PROFISSIONAL COMPULSORY

COURSE DISCRIPTION:

This course introduces the students to the different types of health care facilities and the different categories of health care practitioners. The health care delivery system in Kuwait is described.

COURSE OBJECTIVES:

Upon successful completion of this course the student should be able to:

1. Identify the different elements and facilities in a health care delivery system.
2. Demonstrate understanding of the classification of hospitals, and define the various departments in a general hospital.
3. Identify the different categories of health care practitioners and define the role of each.
4. Describe the organization of the health care delivery system in Kuwait.

COURSE CONTENT:

1. Society and health:
    a. Definition of health and disease.
    b. Importance of health in society.
    c. Influence of society on health.
    d. Health care as a right.
    e. Factors leading to people's increased attention to health care.
2. Elements and facilities in a health care delivery systems:
3. Hospitals:
    a. Definition.
    b. Development of hospitals.
    c. Functions of hospitals.
    d. Classification of hospitals:
        1) According to type.
        2) According to ownership.
        3) According to level of service.
        4) According to accreditation

e. Hospital Departments (function and staff):
    1. Departments concerned with professional care of patients.
        a) Clinical departments.
        b) Diagnostic and therapeutic departments:
            - Laboratory.
            - Radiology.
            - Pharmacy.
            - Physical therapy.
        c) Nursing.
        d) Dietary.
        e) Medical records.
        f) Medical social service.
    2. Departments concerned with business management:
        a) Accounting.
        b) Personnel.
        c) Purchase and supply.
        d) Medical stores.
        e) Maintenance.
        f) Housekeeping.
        g) Public relations.

f. Hospital medical staff:
    i. Classification into open and closed.
    ii. Categories.
    iii. Committees

4. Health care delivery system in Kuwait:

1) Historical development of health services in Kuwait.
2) Philosophy and policies of the Ministry of public Health.
3) Objectives of the Ministry of Public Health.
4) Organization of t6he Ministry of Public Health (central departments).
5) Services provided by the Ministry of Public Health:
    - Primary care: facilities and services.
    - Secondary care: facilities and services.
    - Tertiary care: facilities and services.

6) Regionalization:

a) Characteristics of service delivery system:
    - Availability: concept and measures.
    - Accessibility.
    - Continuity.
    - Costs.

b) Major functions of each region.

c) Service delivery system in a region.

d) Concept of referral.

ASSESSMENT:

4. Quizes 25%
5. Mid-term examination 25%
6. Final examination 50%

REQUIRED TEXTBOOKS:

- Naim, A., Shah, M., Shah, N. and Gomaa.R. Health in Kuwait. Kuwait Ministry of Public Health , 1986.

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MEDICAL RECORDS TECHNICIAN PROGRAM
COURSE SYLLABUS

COURSE TITLE: FILLING SYSTEM

COURSE SYMBOLS AND NUMBER: M.R. 105

CREDITS: 5 (2THEORY, 1 LAB, 2 CLINICAL)

CONTACT HOURS: 12 (2 THEORY, 2 LAB, 8 CLINICAL) PER WEEK FOR 15 WEEKS

PRE-REQUSITE: M.R 103

TYPE OF COURSE: PROFISSIONAL COMPULSORY

COURSE DISCRIPTION:

This course focuses on the storage and retrieval function of the medical record department. It presents the different numbering and filling systems, methods for record control, and recommended periods for retention of different records. Admission policies and procedures are also included. The correlated laboratory is a controlled setting for application and mastery of principles and procedures discussed in lectures. Clinical training in various hospitals provides practice in contact with patients and hospital staff.

COURSE OBJECTIVES:

Upon successful completion of this course the student should be able to:

1. Describe the different numbering systems (with reference to MPI) and filling systems, and discuss the advantages and disadvantages of each.
2. Select the appropriate numbering and filling system for a given situation.
3. Organize and maintain a given system for numbering and filling of medical records.
4. Discuss admission policies and procedures, and follow admission procedures in an admission office.
5. Discuss the various methods available to ensure record searched in a medical record department.
6. Follow procedures for record control in a medical record department.
7. Demonstrate understanding of the microfilming process and prepare medical records for microfilming.
8. State the recommended retention period for different records

COURSE CONTENT:

1. Numbering:
    i. Methods of numbering :
        1) Serial.
        2) Unit.
        3) Serial unit.

ii. Number controls:

1. Responsibility for number allocation.
2. Number index.
3. On-line computer assignment.

iii. Changing from serial to unit numbering.

v. Types of numbers.

2. Master patient index (MPI):

1) Definition and purpose.
2) Content.
3) Arrangement.
4) Filling equipment and supplies.
5) Control for accuracy.
6) Microfilming the master patient index.
7) Automation of the master patient index.

3. Admission policies and procedures:

1. Categories of admission:
   - By medical need.
   - By relation to hospital staff.
   - By financial Arrangement.

2. Admission policies:

   - Authority to admit patients.
   - Persons eligible for admission.
   - Admission priorities.
   - Medical record forms to be completed before admission.

3. Admission procedures:

   i. Checking with patient index and assigning numbers.
   ii. Obtaining information and completing forms.
   iii. Admission discharge register.
   iv. Admission list.
   v. Admission advice slip.
   vi. Bed board

4. Filing:

   1) Methods of filing:
      - Alphabetical .
      - Numerical:
        - Straight numeric.
        - Terminal digit.

2) Changing to terminal digit filing.

3) Filing equipment and supplies:

- Record storage equipment:
  - Types, advantages and disadvantages of each.
  - Estimation of the number of open-shelf filing unit necessary for a given department.
- Guiding the files.
- Protective covers for records.
- Outguides.

4) Organizational of patterns of files.

- Centralization.
- Decentralization.

5) Record control:

- Requisitions.
- Charge out system:
  - Policies.
  - Outguides.
  - Automated chart location system.
- Incomplete records.
- Periodic audits and spot checks.
- Filing rules and procedures.

6) Transportation of records.

4. Retention of medical records:

1) Inactive filing:
   - Factors influencing period of inactive filing.
   - Methods of inactive filing:
     - Storage in another area in the facility.
     - Commercial storage.
     - Microfilming:
       - Advantages.
       - Microfilm cameras.
       - Types of microforms.
       - Preparation of records for filming.
       - Microfilm readers.

2) Retention of records:

i. Factors influencing period of retention of medical records.
ii. Methods of destruction of medical records.
iii. Recommended retention period for different records.

ASSESSMENT:

- Laboratory 15%
- Clinical 25%
- Mid-term examination 20%
- Final examination 40%

REQUIRED TEXTBOOKS:

- Huffman, E. Record Management Medical. Berwyn, Illinois: Physicians Record Co., 1985.

REFERENCES:

- Benjamin, E. Medical Records. London: William Heinmann Medical Books Ltd. ,1977.
- Waters, K. and Murphy, G. Medical Records in Health Information. Rockville, Maryland: Aspen Publishers Inc. , 1979.
- Shurka, M. Organization of Medical Record Departments in Hospitals., Chicago, Illinois: American Hospital Association, 1984.
- Blanchet, K. and Switlik, M. The Handbook of Hospital Admitting Management. Rockville, Maryland: Aspen Publisheres Inc., 1985.

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MEDICAL RECORDS TECHNICIAN PROGRAM
COURSE SYLLABUS

COURSE TITLE: CONTENT AND ANALISYS OF MEDICAL RECORD

COURSE SYMBOLS AND NUMBER: M.R. 204

CREDITS: 4 (2 THEORY, 1 LAB, 1 CLINICAL)

CONTACT HOURS: 8 (2 THEORY, 2 LAB, 4 CLINICAL) PER WEEK FOR 15 WEEKS

PRE-REQUSITE: M.R 105 AND MED. 160

TYPE OF COURSE: PROFISSIONAL COMPULSORY

COURSE DISCRIPTION:

This course focuses on the medical record. It includes a detailed description of the various medical record forms. Principles of forms design and development are outlined. Chart assembly, analysis and abstraction are included. The correlated laboratory is a controlled setting for application and mastery of principles and procedures discussed in lectures. Clinical training in various hospitals provides practice in content with physicians and hospital staff.

COURSE OBJECTIVES:

Upon successful completion of this course the student should be able to:

- Evaluate medical record forms in accordance with general principles of forms design.
- Demonstrate knowledge of the purpose, content, design, responsibility for completion, and standards governing the various medical record forms.
- Describe the difference in arrangement of the medical record during the patient's hospitalization and after the patient has been discharged, and the reason thereof.
- Assemble the medical record after the patient has been discharged according to a given order.
- Analyze the medical record, both quantitatively and qualitatively and complete a deficiency sheet for each record received.
- Abstract information from the medical record for different administrative and research purpose.

COURSE CONTENT:

I. Forms design and development:

A. General principles of forms design.

B. General principles of forms development.

II. Component parts of a conventional medical record:

A. Purpose, content, design, responsibility, for completion, and standards governing the following forms:

- Unit summary sheet.
- Admission summary sheet.
- Authorization sheet.
- Referring letter sheet.
- Medical history sheet.
- Physical examination sheet.
- Physician's orders.
- Clinical progress notes.
- Anaesthesia report.
- Operation report.
- Recovery room record.
- Consultation report.
- Laboratory report.
- Pathology report.
- Radiology report.
- Nurses notes.
- Composite graphic chart.
- Fluid balance sheet.
- Nurses observation sheet.
- Obstetric record.
- Newborn record.
- ECG, EEG, and EMG records.
- Short stay record.
- Autopsy report.
- Clinical discharge summary.
- Emergency room record.
- Outpatient record.

III. Order of arrangement of the medical record:

A. On the nursing unit.

B. For permanent filing.

IV. Problem-orientation medical record.

V. Analysis of the medical record:

A. Required characteristics of medical record entries.

B. Quantitative analysis:

1. Definition and purpose.

2. Component parts.

C. Qualitative analysis:

1. Definition and purpose.

2. Component parts.

D. Incomplete record control:

1. Deficiency notification.

2. Deficiency forms.

3. Filing incomplete records.

VI. Abstracting information from the medical record:

A. Purposes.

B. Method.

ASSESSMENT:

- Laboratory 15%
- Clinical 25%
- Mid-term examination 20%
- Final examination 40%

REQUIRED TEXTBOOKS:

- Huffman, E. Record Management Medical. Berwyn, Illinois: Physicians Record Co., 1985.

REFERENCES:

- Waters, K. and Murphy, G. Medical Records in Health Information. Rockville, Maryland: Aspen Publishers Inc. , 1979.
- Shurka, M. Organization of Medical Record Departments in Hospitals., Chicago, Illinois: American Hospital Association, 1984.

PUPLIC AUTHORITY FOR APPLIEEDUCATION AND TRAINING
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MEDICAL RECORDS TECHNICIAN PROGRAM
COURSE SYLLABUS

COURSE TITLE: CODING AND INDEXING

COURSE SYMBOLS AND NUMBER: M.R. 205

CREDITS: 4 (1 THEORY, 2 LAB, 1 CLINICAL)

CONTACT HOURS: 9 (1 THEORY, 4 LAB, 4 CLINICAL) PER WEEK FOR 15 WEEKS

PRE-REQUSITE: M.R 105 AND MED. 120

TYPE OF COURSE: PROFISSIONAL COMPULSORY

COURSE DISCRIPTION:

This course is designed to train students to code diseases, operations and medical procedures, by using the ninth revision of the International Classification of Diseases (ICD-9) and the International Classification of Procedures in Medicine. Indexes and cancer registry are also included. The correlated laboratory is a controlled setting for application and mastery of procedures discussed in lectures. Clinical training in various hospitals provides in contact with patients and hospital staff.

COURSE OBJECTIVES:

Upon successful completion of this course the student should be able to:

- Differentiate between a nomenclature and classification, and explain the purposes disease and medical procedures classification.
- Trace the history of the International Classification of Diseases.
- Code any given diseases using ICD-9.
- Code any given procedure using the International Classification of Procedures in Medicine.
- Maintain and use different indexes (Disease, operation, physicians).
- Discuss purpose of tumour registry and complete the Kuwait tumour registry forms.

COURSE CONTENT:

I. Classification systems:

A. Introduction:

1. Difference between a nomenclature and a classification.

2. Purpose of classification:

a. standardization.

b. retrieval.

c. statistical analysis.

B. International Classification of Diseases, ninth revision:

1. Historical review.

2. Structure:

a. Contents of Tabular List (volume I) of ICD-9.

b. Arrangement of tabular list of inclusions and fourth digit subdivisions:

- Chapters
- sections
- Category codes.
- Subcategory codes.

c. Section of Alphabetic Index (volume II) of ICD-9:

- Section 1: diseases and nature of injury, and supplementary classification.
- Section 2: external causes of injury.
- Section 3: drugs and other chemicals

d. International Classification of Procedures in Medicine:

- Content of volume I.
- Content of volume II

e. Code numbers:

- Diseases supplementary classification.
- External causes of injury.
- Procedure.

3. Abbreviations, punctuations and other conventions:

a. Abbreviations:

- NOS
- NEC

b. Punctuations:

- Parenthesis
- Brace
- Colon
- Dagger and asterisk.

c. other conventions:

- See
- See also
- Includes

- Excludes

4. General coding principles:

   a. Four basic coding steps.

   b. Use of alphabetic index:

      - Primary arrangement
      - Indentations under main entries
      - Eponyms

   c. Suspected diagnosis

   d. Suspected diagnosis, ruled out

   e. Symptoms, signs and ill-defined conditions

   f. Congenital anomalies

5. Coding of neoplasms:

   a. Classification of neoplasms

   b. Coding of primary

   c. Follow up

6. Obstetrical coding:

   a. Abortion: types and complications

   b. Pregnancy: normal and complicated.

   c. Delivery: normal and complicated

   d. Puerperium: normal and complicated

   e. Infants

   f. Obstetrical procedures

7. Injuries:

   a. Fractures:

      - Closed and open.
      - Reduction and fixation.
      - Aftercare.

   b. Open wounds: complicated and not complicated.

   c. Burns: degree.

   d. Complications of surgical and medical care.

e. Drugs and chemicals.

f. Late effect codes.

g. External cause of injury.

II. Indexes:

A. Disease and operation indexes:

1. Uses.

2. Content.

3. Types:

a. Manual:

- Filing equipment
- Design of index cards
- Arrangement of cards

b. Automated.

4. Maintenance

5. Retrieval from indexes

B. Physician' index:

1. Uses.

2. Content

3. Confidentiality

4. Types:

a. Manual:

- Equipment
- Arrangement of cards

b. Automated

III. Cancer registry:

A. Definition and purpose

B. Types

C. Components

D.Tumour registrar

E. Cancer registry procedures

F. Computerized cancer registry in Kuwait

ASSESSMENT:

- Laboratory 20%
- Clinical 20%
- Mid-term examination 20%
- Final examination 40%

REQUIRED TEXTBOOKS:

- International Classification of Diseases, ninth revision (volumes I & II). Geneva: World Health Organization, 1975.
- International Classification of Procedures in Medicine (volume I & II). Geneva: World Health Organization, 1978.
- Huffman, E. Record Management Medical. Berwyn, Illinois: Physicians Record Co., 1985.

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COURSE SYLLABUS

COURSE TITLE: MANAGING MEDICAL RECORD

COURSE SYMBOLS AND NUMBER: M.R. 206

CREDITS: 5 (2 THEORY, 1 LAB, 2 CLINICAL)

CONTACT HOURS: 12 (2 THEORY, 2 LAB, 8 CLINICAL) PER WEEK FOR 15 WEEKS

PRE-REQUSITE: M.R 204 AND MED. 205

TYPE OF COURSE: PROFISSIONAL COMPULSORY

COURSE DISCRIPTION:

This course presents the presents the principles of management, with special reference to application in the medical record department. Quality assurance and legal aspects of medical records are included. The correlated laboratory is a controlled setting for application and mastery of principles and procedures discussed in lectures. Clinical training in various hospitals provides practice in contact with patients and hospital staff.

COURSE OBJECTIVES:

Upon successful completion of this course the student should be able to:

- Demonstrate understanding of the principles of management.
- Apply principles of management in supervision of personnel in various units of the medical record department.
- Demonstrate understanding of the purpose and methods of the different elements of quality assurance.
- Retrieve and present information for quality assurance programs.
- Demonstrate awareness of the legal aspects of medical records.

COURSE CONTENT:

I. Management:

A. Definition of management.

B. Components of Management.

C. Planning function:

1. Definition of planning.

2. Steps of the process of planning.

3. Goals and objectives.

4. Polices.

5. Procedures.

6. Rules.

D. Organization and staffing function:

1. Definition of organizing and staffing.

2. Departmentation.

3. Coordination.

4. Authority and responsibility.

5. Span of control.

6. Delegation.

7. Organization chart.

8. Job analysis and job description.

9. Work distribution chart.

10. Organizing the work environment.

E. Directing function:

1. Definition of directing.

2. Leadership:

a. Definition of leadership

b. Sources of power.

c. Leadership styles.

3. Motivation:

a. Definition of motivation.

b. Theories of motivation:

- McGregor's theory X and theory Y.
- Maslow's theory X and Y.
- Hertzberg's hierarchy of needs.

4. Communication:

a. Definition of communication.

b. The communication process.

c. Mean of communication.

d. Barriers to communication.

5. Work simplification:

a. Definition.

b. Flow process chart.

6. Performance appraisal.

F. Controlling function:

1. Definition of controlling.

2. Standards:

a. Definition of standard.

b. Methods of setting standards.

3. Monitors:

a. Input output logs.

b. Time logs.

c. Stopwatch time study.

d. Direct inspection.

e. Checklist.

f. Audit.

g. Questionnaires completed by consumers.

h. Reports.

4. Corrective action and follow up.

II. Quality assurance:

A. Utilization management:

1. Forms of inappropriate utilization of health services.

2. Purpose of utilization management.

3. Types of utilization review:

a. Preadmission review.

b. Concurrent review.

c. Retrospective review.

4. Types of screening criteria:

a. Diagnostic specific.

b. Serverity of illness/intensity of service.

B. Quality assessment:

1. Purpose of quality assessment.

2. Methods:

a. Statistical indicators.

b. Individual case reviews.

3. Criteria:

a. Implicit.

b. Explicit.

C. Risk management:

1. Purpose of risk management.

2. Elements of risk management:

a. Identificaton.

b. Analysis.

c. Evaluation.

d. Elimination or reduction of risks.

D. Quality assurance committees.

E. Role of medical record practitioners in quality assurance.

III. Legal aspects of medical records:

A. The requirement to keep medical records.

B. Ownership of the record.

C. Confidentiality of medical record.

D. Release of information from medical records.

E. Informed consents.

F. Ammending the medical record.

G. Retention of medical records.

H. Legal aspects of microfilmed medical records.

I. Legal aspects of automated medical records.

ASSESSMENT:

- Laboratory 15%
- Clinical 25%
- Mid-term examination 20%
- Final examination 40%

REQUIRED TEXTBOOKS:

- Huffman, E. Record Management Medical. Berwyn, Illinois: Physicians Record Co., 1985.
- Imbiorski, W., Fox, L., Samuels, C., Stearns, G. and Brewer, E., Evaluation the quality of Medical Record Services. Chicago, Illinois American Medical Record Association, 1979.

REFERENCES:

- Liebler, J. Managing Health Records- Administrative Principles. Rockville, Maryland: Aspen Publishers Inc., 1980.
- McConnel, C., The Effective Health Care Supervisor. Rockville, Maryland: Aspen Publishers Inc., 1982.
- Graham, N. Quality Assurance In Hospitals. Rockville, Maryland: Aspen Publishers Inc., 1982.
- Roach, W., Chernoff, S. and Esley, C. Medical Records and the law. Rockville, Maryland: Aspen Publishers Inc., 1982.

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COURSE SYLLABUS

COURSE TITLE: HEALTH INFORMATION SYSTEM

COURSE SYMBOLS AND NUMBER: M.R. 207

CREDITS: 4 (2 THEORY, 2 LAB, 1 CLINICAL)

CONTACT HOURS: 8 (2 THEORY, 2 LAB, 4 CLINICAL) PER WEEK FOR 15 WEEKS

PRE-REQUSITE: M.R 205 AND MED. 107

TYPE OF COURSE: PROFISSIONAL COMPULSORY

COURSE DISCRIPTION:

This course introduces the student to the different uses of health information. It includes collection, presentation, and interpretation of different types of health data and information, grouped as vital statistics, morbidity measures, and hospital statistics. Theories learned in lectures are practiced in the laboratory and in the statistical unit of various Ministry of Health hospitals. Visits to the central statistical department are also included.

COURSE OBJECTIVES:

Upon successful completion of this course the student should be able to:

- Indicate through examples the role of vital and health statistics and the health care field
- Describe the system for recording, reporting and registration of birth and death in Kuwait, with special reference to the role of the medical record practitioners.
- Identify different sources of information for various vital and health statistics.
- Compute the various vital and health statistics.
- Interpret and discuss the advantages and limitation of various vital and health statistics.

COURSE CONTENT:

I. Role of information in the health care field.

II. Vital statistics:

A. Definition.

B. Census of population:

1. Definition.

2. Types and features of each type.

3. Characteristics of the population.

4. Use of census data in the health care field.

5. History of the census in Kuwait.

6. Components of population change: birth, death and migration.

7. Importance of projecting size and characteristics of a population.

C. Registration of birth and deaths:

1. Reasons for birth and death.

2. Definition of terms related to reporting of births and deaths.

3. System for recording, reporting, and registration of births and deaths in Kuwait:

a. Livebirths.

b. Fetal deaths.

c. Deaths.

D. Measures of fertility: computation, inerpretation, advantages and limitations of:

1. Crude birth rate.

2. General fertility rate.

3. Age-specific fertility rate

E. Measures of mortality: computation, interpretation, advantades and limitations of:

1. Crudes deaths rate.

2. Age-specific death rate.

3. Sex-specific death rate.

4. Cause-specific death rate.

5. Proportional mortality rate.

6. Maternal mortality rate.

7. Infant mortality rate.

8. Neonatal mortality rate.

9. Post-neonatal mortality rate.

10. Lat fetal death rate.

11. Perinatal death rate.

III. Morbidity statistics:

A. Value of morbidity statistics.

B. Measures of morbidity: Computation, interoretation, advantages and limitation of:

1. Incidence rate.

2. Prevalence rates.

3. Case-Fatality rate>

C. Sources of morbidity data:

1. Medical records:

a. Types and limitation of:

- Hospital records: inpatient, outpatient, emergency room.
- Primary health care units.

b. Data collected and abstraction forms and in Kuwait.

2. Other historical sources: diseases registers, notification of diseases, sickness absence records, etc.

3. Health surveys.

IV. Hospital statistics:

A. Daily discharge analysis.

B. Common hospital rates and percentages as indicators of the quality of hospital services:

1. Hospital death rates:

a. Gross death rate.

b. Net death rate.

c. Maternal death rate.

d. Fetal death rate.

e. Neonatal death rate.

f. Perinatal death rate.

g. Anaesthesia death rate.

h. Postoperative death rate.

2. Infections:

a. Hospital infection rate.

b. Postoperative infection rate.

3. Autopsy rates:

a. Hospital autopsy rate.

b. Net autopsy rate.

4. Cesarean Section rate.

5. Consultation rates.

C. Hospital daily census and rates computed from it:

1. Definition of terms.

2. Compilation of word and hospital census.

3. Rates computed from daily census: computation, interretation, advantages and limitations of:

a. Average daily census.

b. Bed occupancy rate.

c. Bed vacancy rates.

d. Turnover interval.

e. Turnover rate

f. Average length of stay.

D. Hospital outpatient statistics:

1. Definition of terms.

2. Community computed rates.

E. Measures of volume of services provided by different departments.

ASSESSMENT:

- Laboratory 20%
- Clinical 20%
- Mid-term examination 20%
- Final examination 40%

REQUIRED TEXTBOOKS:

- Huffman, E. Record Management Medical. Berwyn, Illinois: Physicians Record Co., 1985.
- Glossary of Hospital Terms. Chicago, Illinois: American Medical Record Association, 1983.

REFERENCES:

- Daniel, W. Biostatistics : A Foundation for Analysis in Health Sciences. New York: Wiley and Sons, 1978.
- Bradford, A. A Short Textbook of Medical Statistics. London: Hodder and Stought, 1977.
- Broyles and lay. Statistics in Health care Administration. Rockville, Maryland: Aspen Publishers, Inc., 1979.

PUPLIC AUHORITY FOTR APPLIEEDUCATION AND TRAINING
COLLEGE OF HEALTH SCIENCES
MEDICAL RECORDS TECHNICIAN PROGRAM
COURSE SYLLABUS

COURSE TITLE: COMPUTER APPLICATION FOR MEDICAL RECORDS

COURSE SYMBOLS AND NUMBER: M.R. 208

CREDITS: 3 (2 THEORY, 1 LAB)

CONTACT HOURS: 4 (2 THEOR, 2 LAB) PER WEEK FOR 15 WEEKS

PRE-REQUSITE: M.R 108 AND MED. 204

TYPE OF COURSE: PROFISSIONAL COMPULSORY

COURSE DISCRIPTION:

This course introduces the students to the different aspects of the use of computers in the Medical Records Department. In this context, the course demonstrates how computer technology can be used as a primary tool in the hospital and especially in the medical record department. The laboratory is used for the application of learned concepts.

COURSE OBJECTIVES:

Upon successful completion of this course the student should be able to:

- Identify and use the range of computer applications favoured in a contemporary Medical Record Department.
- Describe the retionale for the use of the term patient data.
- Describe the process of change in the computerization of the Medical Record Department.
- Describe the role of the medical record practitioner in computerization of patient data.
- Develop descriptive profiles for each functional operation in the Medical Record Department in preparation for automation.
- Define and describe Medical Information structure through the evaluation of an individual patient treatment and its relation to providers and other users through the facility.
- Explain the significance of the registration, admission, discharge, and transfer functions in the development of integrated information system and as the data base.
- Explain how automation has improved and streamlined manual medical record processing.

COURSE CONTENT:

I. Computer systems found in health facilities.

II. Patient data as an information source.

III. The role of the computer in streamlining the functions of the Medical Record Department.

IV. The role of the medical record practitioner in computerization of patient data.

V. Data Base and Master Patient Index as the core of Health Information System.

VI. Different ways of information entry:

A. Batch.

B. On-line .

VII. Computerized record location and tracking systems.

VIII. Computerized chart completion system.

IX. Computerized discharge abstraction system.

X. Computerized census and statistics preparation and distribution.

XI. Computerized-supported diagnostic and procedural coding and indexing.

XII. Computerizing quality assurance activities.

XIII. Transcription and word processing.

ASSESSMENT:

- Laboratory 20%
- Clinical 20%
- Mid-term examination 20%
- Final examination 40%

REQUIRED TEXTBOOKS

- Handouts given by instructor.
- Waters, K. and Murphy, G. Systems Analysis and Computer Applications in Health Information Management. Rockville, Maryland: Aspen Publishers Inc. , 1983.
- Christensen, W. and Stearns, E. Microcomputers in Health care Management. Rockville, Maryland: Aspen Publishers Inc., 1984.
- Blumm, B. Information Systems for Patient Care. New York: Springer-Verlag, 1984.

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COLLEGE OF HEALTH SCIENCES
MEDICAL RECORDS TECHNICIAN PROGRAM
COURSE SYLLABUS

COURSE TITLE: SUMMER PRACTICUM

COURSE SYMBOLS AND NUMBER: M.R. 209

CREDITS: 3 (CLINICAL)

CONTACT HOURS: 30 HOUERS PER WEEK FOR 6 WEEKS

PRE-REQUSITE: M.R 204 AND MED. 205

TYPE OF COURSE: PROFISSIONAL COMPULSORY

COURSE DISCRIPTION:

Assignment to various hospitals for practical application of theories learned in lectures and applied in laboratories, in contact with patient and hospital staff.

COURSE OBJECTIVES:

Upon successful completion of this course the student should be able to:

- Follow procedures in all areas of the medical record department.
- Identify problems in the different areas of the medical record department and suggest solution.

COURSE CONTENT:

1. Admitting office	12 hours
2. Clinics	12 hours
3. Casuality	12 hours
4. Wards	12 hours
5. Master Petient Index	12 hours
6.Filing areas	30 hours
7. Chart assembly and analysis	30 hours
8. Coding and indexing	30 hours
9. Statistics	30 hours

ASSESSMENT:

1. Reports (evaluated by faculty member) 30%

2. Clinical evaluation (by clinical instructor):

- Quality of work. 30%
- Application to work. 20%
- Professionalism. 10%
- Attendance. 10%