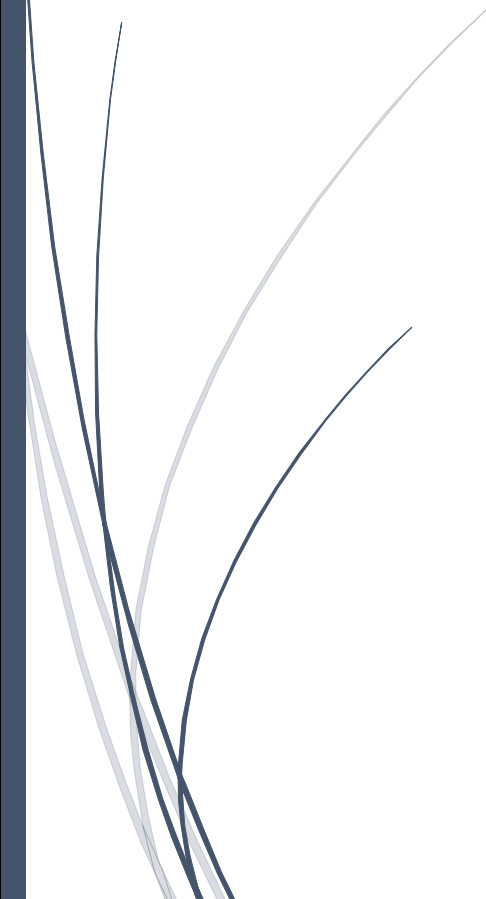# HOSPITAL RECORD MANAGEMENT SYSTEM

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ABSTRACT

EXISTING PROJECT

Hospital currently uses a manual system for the management and maintenance of critical information. The current system requires numerous paper forms, with data store spreads throughout the management infrastructure. Often information is incomplete or does not follow management standard. Forms are often lost in transit between departments requiring a comprehensive auditing process to ensure that no vital information is lost. Multiple copies of the same information exist in the hospital and may led to inconsistencies in data in various data stores.

A significant part of the operation of any hospital involves that acquisition, management and timely retrieval of great volumes of information. This information typically involves patient personal information, and medical history, staff information and ward scheduling, staff scheduling and other information.

DRAWBACKS OF THE EXISTING SYSTEM

❖ Records may have lost due to careless handling

- ❖ They cannot be searched quickly when a decision must be made by the care provider at the point of care.
- ❖ If the records are too large, additional expense must be budgeted to pay for off-site storage.
- ❖ A paper record can be used only for one task at a time
- ❖ Poor security – Permanent loss of records through theft, fire and similar as there are no virtual back-ups.

PROPOSED SYSTEM

The Hospital Management System is designed for any hospitals to replace their existing manual paper based system. The new system is to control the following information such as patient information, room availability, staff and operating room schedules, etc. These services are to be provided in an efficient and cost effective manner, with the goal of reducing the time and resources currently required for such task

ADVANTAGES OF PROPOSED SYSTEM

- ➢ Providing accurate, up-to-date, and complete information about patients at the point of care
- ➢ Enabling quick access to patient records for more coordinated, efficient care
- ➢ Securely sharing electronic information with patients and other clinicians

- Helping providers more effectively diagnose patients, reduce medical errors, and provide safer care
- Improving patient and provider interaction and communication, as well as health care convenience
- Enabling safer, more reliable prescribing
- Helping promote legible, complete documentation and accurate, streamlined coding and billing