Ministry of Education and Science of Ukraine
V. N. Karazin Kharkiv National University

ORGANIZATION AND CONTENT OF WORK OF HOSPITALS OF DIFFERENT LEVELS, ACCOUNTING AND ANALYSIS OF THEIR ACTIVITY. INPATIENT FORMS OF CARE DELIVERY

Methodical recommendations
to prepare 3rd–4th year students for practical classes
for the discipline of «Social Medicine, organization of health care»

Electronic resource

Kharkiv – 2024

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О 72

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О 72 **Organization** and content of work of hospitals of different levels, accounting and analysis of their activity. Inpatient forms of care delivery: methodical recommendations to prepare 3rd–4th year students for practical classes for the discipline of «Social Medicine, organization of health care» [Electronic resource] / compilers : O V. Bobrova, N. H. Tsukor. – Kharkiv : V. N. Karazin KhNU, 2024. – (PDF 32 p.)

The methodical recommendations set out the main aspects of the organization and content of work of hospitals of different levels, accounting and analysis of their activity. Inpatient forms of care delivery. For 3rd–4th year students to prepare for independent work in the discipline «Social Medicine, organization of health care». Methodical recommendations contain a list of tasks for performing situational tasks, test questions, a list of recommended and additional literature from the main sections of the course.

УДК 614.21(072)

CONTENT

1. INTRODUCTION

The curriculum of the discipline “Social medicine, organization of health care” is developed in accordance with the Educational Program of specialists’ training at the second (master's) degree for 222 "Medicine" Specialty in the field of knowledge 22 “Healthcare”.

Characteristics of the academic discipline
"Social medicine, organization of health care"

<table>
<tr><td>Name
indicators</td><td>Field of knowledge, direction of training, educational and qualification level</td><td>Characteristics of the academic discipline
full-time education</td></tr>
<tr><td rowspan="3">3rd-4th</td><td></td><td>Normative</td></tr>
<tr><td rowspan="6">Specialty:
222
"Medicine"</td><td>A year of training</td></tr>
<tr><td>3rd-4th</td></tr>
<tr><td rowspan="2">The total number of hours is 180</td><td>Semester</td></tr>
<tr><td>3rd-4th</td></tr>
<tr><td rowspan="7"></td><td>Lectures</td></tr>
<tr><td rowspan="7">Educational and qualification level: master's degree
Qualification: doctor</td><td>30 hours</td></tr>
<tr><td>Practical training</td></tr>
<tr><td>60 hours</td></tr>
<tr><td>Independent work</td></tr>
<tr><td>90 hours</td></tr>
<tr><td>Type of control</td></tr>
<tr><td>Differentiated scoring</td></tr>
</table>

The purpose of teaching the discipline

The purpose of the "Social medicine, organization of health care" discipline is to provide sufficient knowledge of research, analysis and evaluation of public health indicators, the health care system and to improve the organization of medical care and public health structure for medical students.

2. RECOMMENDATIONS FOR STUDYING THE TOPIC

Goal: to study targets and main tasks of inpatient facilities, their units and functions. To know procedure for referral of patients to all type of inpatient facilities. To be able to fill in basic documentation used for accounting of the hospital. To determine and analyze of hospital performance indicators.

Methodical support:

1. Methodical literature: workbook for students (basic training);
2. Presentation materials;
3. Samples of documents: - Inpatient medical record (f.003/o); Statistical card of patient discharged from hospital (f. 066/o); Patient's informed voluntary consent to conduction of diagnosis, treatment, and to conduction of operation and anesthetization (f. 003-6/o) Medical prescription sheet (f. 003-4/o) Extract from the medical card of an outpatient (inpatient) (f. 027/o) Register of patients receiving in-patient (f. 001/o); Protocol of patho-anatomical investigation (f. 013/o);
3. Tables and formulas for calculating the performance indicators of an inpatient facilities;
4. Test tasks;
5. Lecture course.

As a result of self-training, the student must know:

- The content and organization of work of the intern and chief physician
- Factors affecting the efficient use of hospital beds and the effectiveness of hospitals.
- The main documentation used to record the work of the hospital, the content and procedure for its completion.
- Types of hospital replacement institutions.
- The structure of day patient facilities.
- Functions of day patient facilities and a hospital at home.

- Basic documentation of the day patient facilities and hospital at home, filling it.

As a result of studying the subject, the student should be able to:

- calculate and analyze the effectiveness of the hospital according to the report of the medical institution (f. No. 20).
- know the procedure for referring patients to day care and in-patient care at home.
- calculate and analyze performance indicators of a day hospital and a hospital at home.
-complete the medical records used for analyze performance indicators of inpatient facilities
- analyze and effective use of the knowledge and skills.
-develop of measures to improve of inpatient facilities, day patient facilities and a hospital at home.

Method of conducting a lesson:

1. Control of the initial level of knowledge of students.
2. The practical work of students:
 - An explanation of the concept of "inpatient facilities";
 - An explanation of the types of hospital replacement institutions, their functions and main tasks;
 - Fill in medical records used for analyze performance indicators of inpatient facilities
 - Calculate and evaluate the indicators of performance of an inpatient facility.
 - Study the basic legal documents of Health care of Ukraine.
3. Control of the final level of student`s knowledge by test control and questioning students. Rating.

Questions for self-preparation of students for practical training:

1. The advantages of hospital-replacing forms of medical care.
2. The main forms of hospital-replacing technologies.

3. Contraindications for hospitalization in a day hospital.
4. Pros and cons of the hospital at home.
5. Characteristics of one-day hospitals.
6. Other hospital-replacing forms of medical care.
7. Indicators and analysis of hospital-replacing forms of medical care.

3. BASIC THEORETICAL MATERIAL FOR PREPARATION TO THE LESSON

Inpatient facilities of various levels play a vital role in health service delivery systems across the Ukraine. Many countries struggle to improve hospital planning and management, at both the facility and health system level. Facility-level challenges include weak management, inefficiencies, high costs and poor clinical governance, quality and safety. At the system level, challenges include limited integration and coordination with other hospitals and primary health care, inadequate feedback mechanisms and procedures, perverse financial incentives and weak regulation. These challenges occur against the backdrop of rapid population ageing, the predominance of chronic health conditions, financial and service pressures, new medical technologies and pharmaceuticals, growing provision of private care and increasing public expectations. Given the importance of an inpatient facilities and the range of challenges, improving hospital planning and management is a critical issue for our country. Progress towards universal health coverage requires a whole-of-system approach, linking hospitals to other parts of the health system, to ensure equitable delivery of integrated, people-centered services, with due reorientation towards primary care.

Hospitals and healthcare organizations are today operating in an extremely competitive environment, with increasing pressure to improve quality and reduce costs. In responding to this dynamic situation, transformation of organization requires the will to organize delivery around the needs of patients.

4. INPATIENT (HOSPITAL) CARE

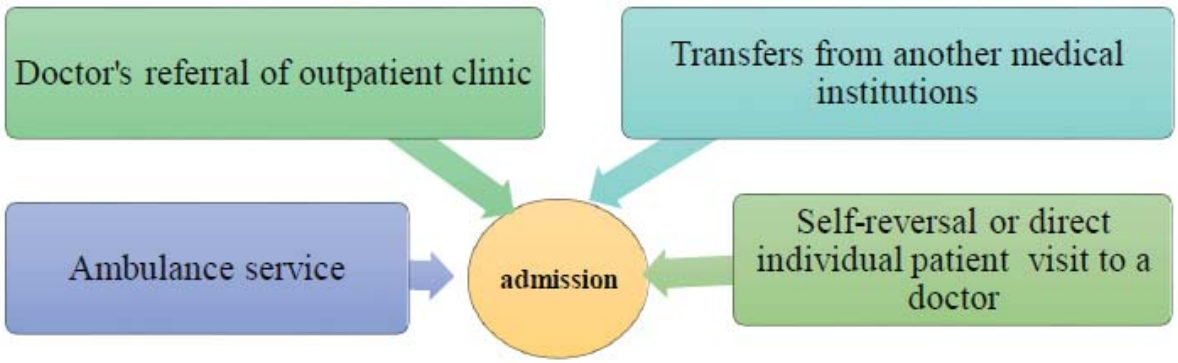
Inpatient (hospital) care is provided to patients requiring long-term (constant/permanent) follow-up, using of complicated methods of examination and intensive treatment, and also operative interventions that cannot be performed in out-patient conditions.

Patients can be treated in the hospitals with various pathological conditions or with one certain pathology.

Types of the hospital care:

1. Total health care.
2. Specialized care.

Hospitalization (admission) is carried out by doctor's referral of out-patient clinics and ambulance service, transfer from another hospital, and also at the direct address to the doctor in the presence of emergency indications.



Hospital tasks:

1. Providing of the specialized round-the-clock stationary care in sufficient volume
2. Approbation and introduction of modern methods of diagnostics, treatment and prevention.
3. Comprehensive rehabilitation treatment
4. Disability expertise
5. Hygienic education of the population

Hospital functions:

Therapeutic and recovery function	Treatment, medical rehabilitation, diagnosis, emergency care etc.
Preventive function	Prevention of infection diseases, prevention the transition of the acute forms to chronic forms etc.
Educational function	Training of medical personnel, improvement professional skills
Scientific research function	Conducting clinical trials, implementation of new method of treatment

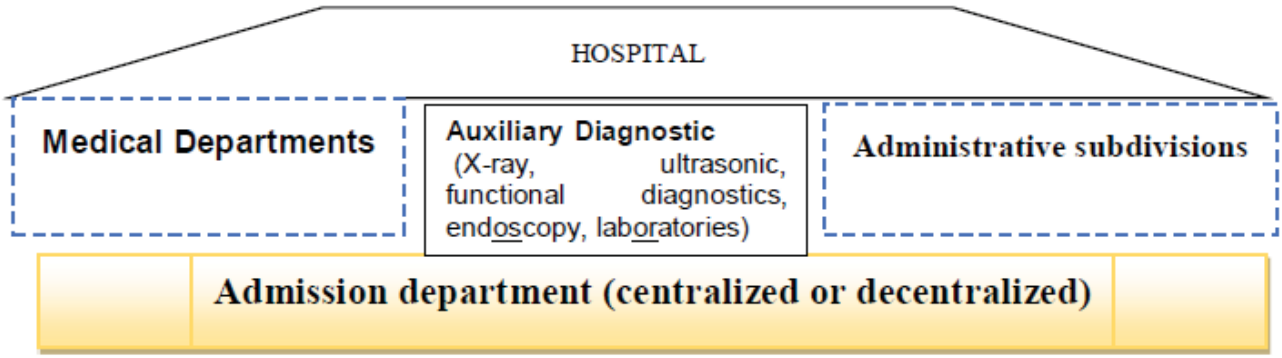
Indications for referring the patient to a hospital:

1. The presence of emergency or emergency indications.
2. The need for complex research.
3. The use of intensive methods of treatment.
4. Social and living conditions of the patient.

The structural units of the hospital:

1. Reception department.
2. Medical departments.
3. Auxiliary diagnostic units.
4. Administrative divisions.

Subdivisions of a hospital:

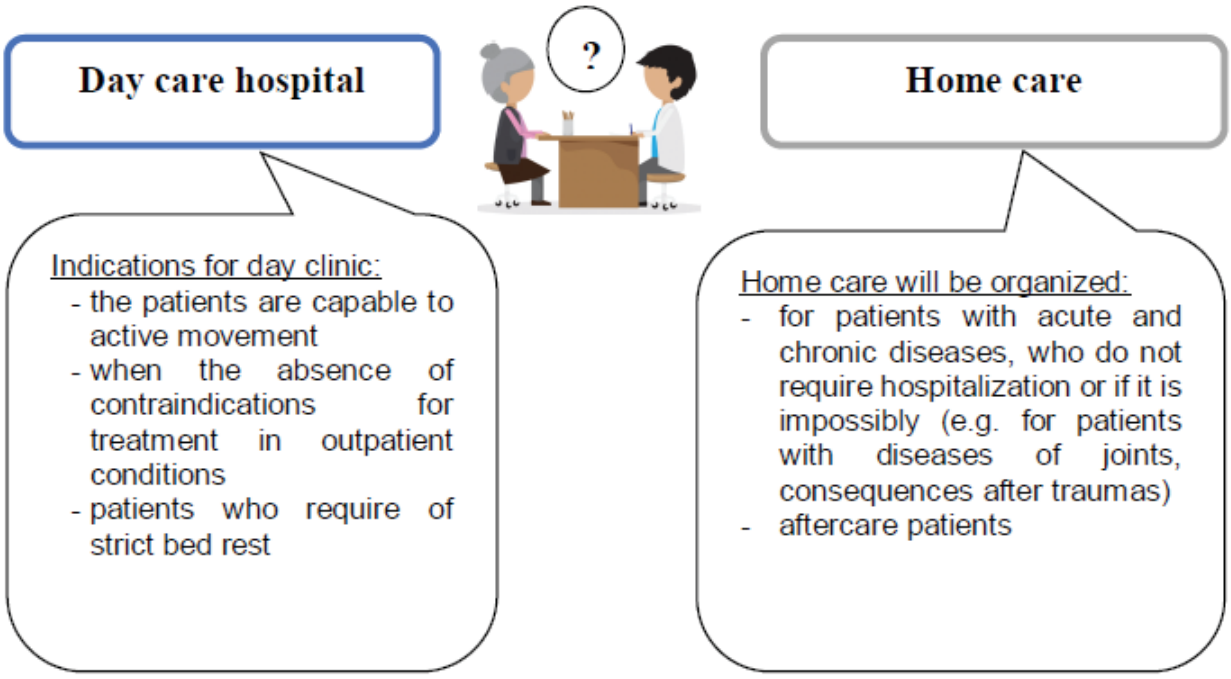


5. TYPES OF HOSPITAL-REPLACING FACILITIES

Types of hospital-replacing facilities:

1) day hospitals in clinics;

2) hospitals at home.



Patients capable of active movement are sent to a day hospital in the absence of contraindications for treatment in community-acquired conditions and the need for strict bed rest.

The task of the day hospital is to provide medical care for patients who are capable of active movement, in the absence of contraindications for treatment in community-acquired conditions and the need for strict bed rest.

Functions of the day hospital:

1) active planned recovery and treatment of dispensary patients who are often ill for a long time;

2) reduction of the period of temporary incapacity for work;

3) conducting in outpatient settings of some diagnostic studies;

4) expansion of the scope of surgical interventions.

All this contributes to the rational use of the bed fund.

The structure of the day hospital:

1) the office of the head of the department;

2) doctor's office;

3) wards for day stay of patients;

4) surgical dressing unit;

5) intensive care unit;

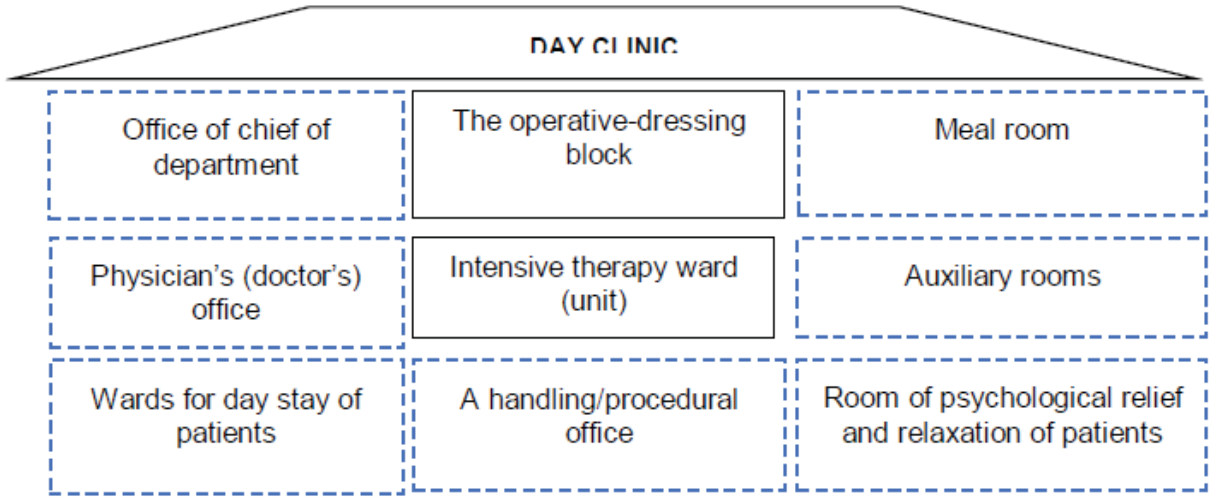
6) a room for eating;

7) an office of psychological unloading and rest of patients;

8) manipulation / treatment room;

9) auxiliary facilities.

Structure of day clinic includes:



A home hospitalization is organized for patients with acute and chronic diseases who, for health reasons, do not need hospitalization or if it is not possible due to various circumstances (for example, for patients with joint diseases, consequences of injuries, for patients with cerebrovascular diseases).

Functions of hospital at home:

1) the diagnosis and treatment of diseases in accordance with the indications for hospitals at home;

2) aftercare of the patients after the intensive treatment stage using modern means and methods of community-based medical care;

3) the relationship and continuity of health facilities with social protection authorities.

The procedure for referring patients to a day hospital and a hospital at home.

The selection of patients for hospitalization in a day hospital is carried out by the heads of the medical departments of the outpatient clinics upon presentation:

1) district therapists,

2) district pediatricians,

3) general practitioners - family doctors,

4) other specialists of the medical institution on the basis of which it operates.

Advantages of home care:

1) it is economically feasible (5 times cheaper than a 24/7-stay inpatient facility) and, assuming the

circumstances are adequate, just as effective as treatment in a 24/7-stay inpatient facility;

2) greater psychological comfort (during treatment, patient stays in a familiar home environment).

3) adaptation of a patient for the actual environment he will live in.

Disadvantages of home care:

1) it is difficult to organize medical monitoring of a patient's status, which is especially critical for

severely ill ones. A doctor stays with the patient about 2–3 hours per day, while for the rest of the

day (21–22 hours) the patient is attended by relatives or nurses who, usually, do not possess medical

education;

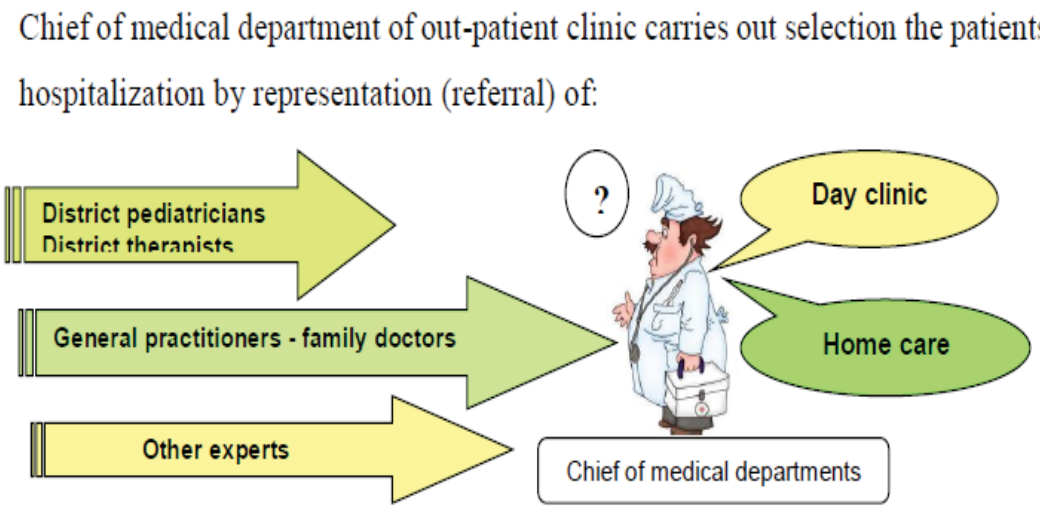
2) huge labor intensity of treatment. A doctor can serve no more than 3–4 patients per day;

3) engaging additional specialists is complicated, which leads to increased treatment costs;

4) some kinds of physical treatment are impossible in home conditions.

Each hospital in each country is given a score. Scores are only comparable between hospitals in the same country, as each country looks at different sources of patient experience and healthcare key performance indicators. As these data are not harmonized, it may be inaccurate to compare the performance of hospitals in different countries by using this score (for example, a score of 90 in country A does not necessarily mean that this hospital is better than a hospital with a score of 87 in country B).

But the top five hospitals are all from North America, so are relatively less affected by this. However, the overall ranking of the journals is based on international recommendations from peers in different countries and incorporates the scores obtained by the hospitals. Therefore, the top five hospitals in the ranking are comparable.



Chief of medical department carries out the management of a day hospital of polyclinic establishment. Head physician carries out the management of a day hospital at the dispensary.

6. A PRAGMATIC APPROACH TO MANAGING POLITICAL ECONOMY CONSIDERATIONS

The Commission builds on the application of political economy analysis to health financing by explicitly considering broader social, political, and economic features of a context that can influence the success or failure of PHC financing functions and reform efforts, as well as their evolution. Political economy analysis framework, shown in figure 1, takes into consideration three domains that influence financing for primary health care (PHC).

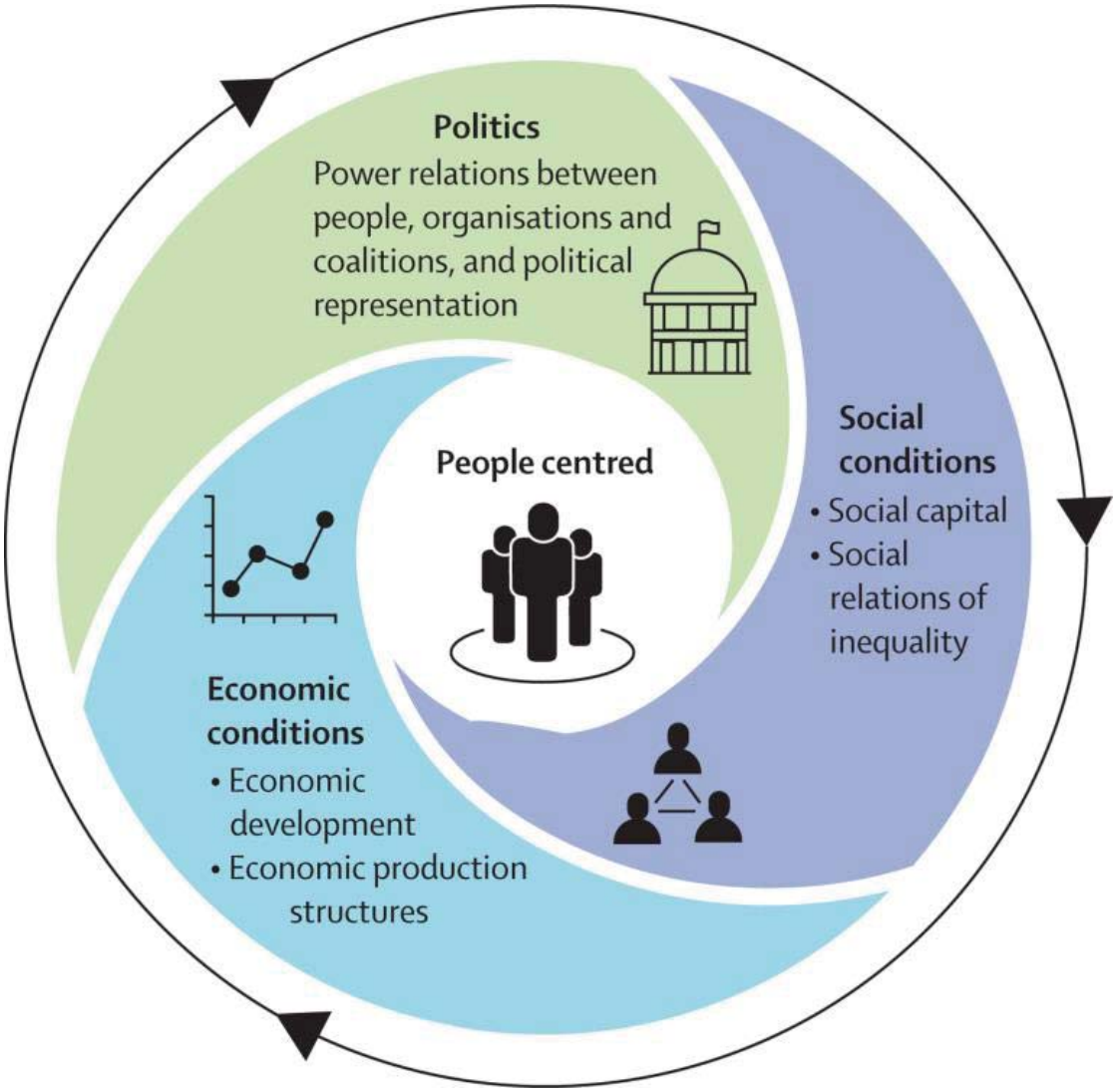


Figure 1.

A political economy analysis conceptual framework for health financing reform

First, politics: including the range of actors (individuals, formal and informal organizations, and institutions) and their respective power, their relationships and contracts, their legitimacy, as well as contestation leading to the enactment of policies.

Second, social conditions: encompassing social values, informal networks, class, caste, or other social constructs that can influence, for example, the options for distribution or redistribution of resources, including acceptance of, or resistance to, reforms such as greater pooling of resources.

Third, economic conditions: including a country's level of economic development, production structures, levels of taxation and levels of aid, that facilitate or hamper the mobilization of resources to PHC.

The Commission's deliberations have analysed how health financing arrangements can be used to drive national health systems to provide equitable, comprehensive, integrated, and high-quality PHC, delivered through platforms that are responsive to the needs of the populations they serve, and fully aligned with the objectives of UHC.

Therefore, countries should invest more and invest better in PHC, and that the financing arrangements that support PHC—from mobilization and pooling of resources, to budgeting, allocation, and purchasing—must place people at the centre. They must also be driven by a focus on equity and social justice, in line with the original Alma Ata vision. The features of people-centred financing for PHC below. The opportunities to reorient health financing policies towards PHC depend on the economic, social and political features of a particular regional, national, or sub-national context, and that there is no single pathway to achieving optimal PHC financing (figure 2).

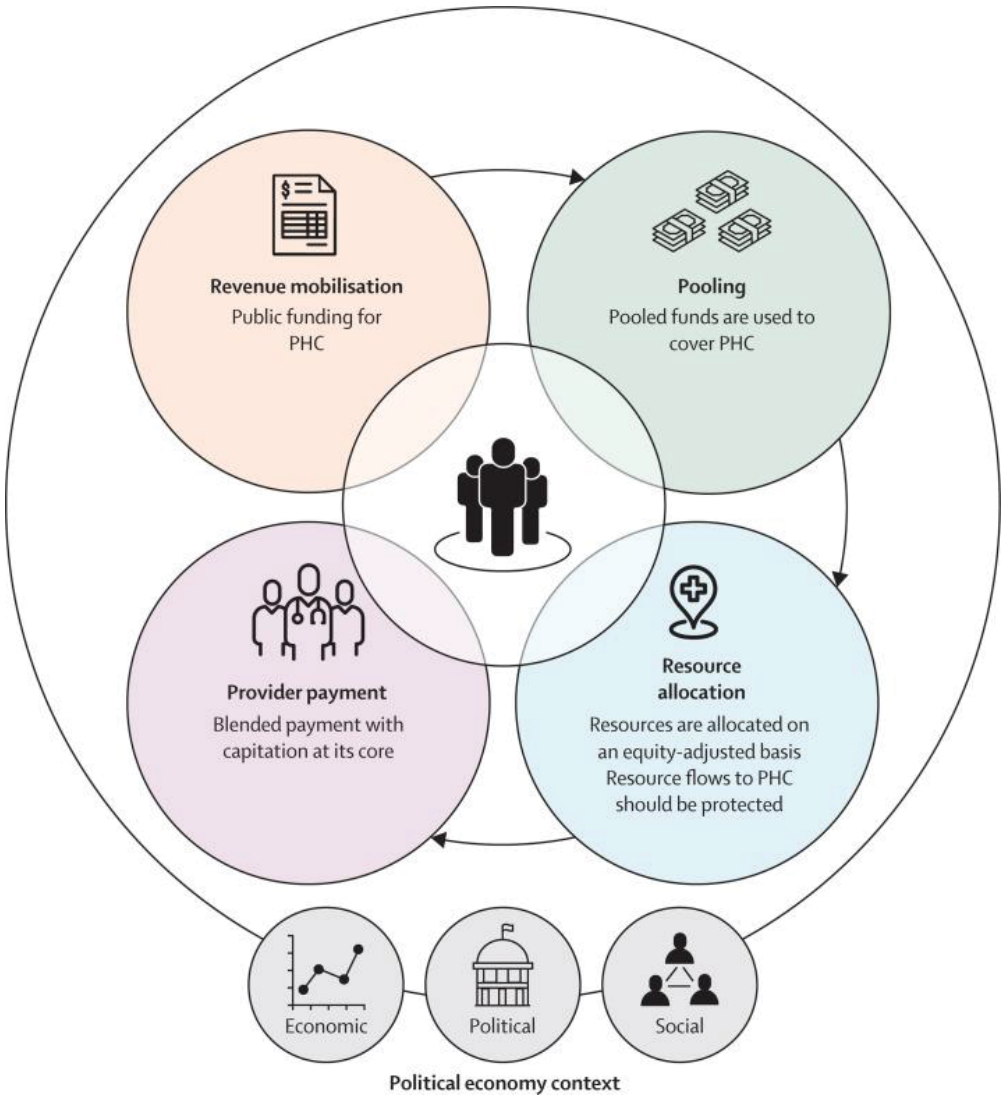


Figure 2.

Framework for people-centred financing of Primary health care (PHC)

An overarching position of the Commission has been the principle of progressive universalism: This means that governments should prioritise equity by providing universal access to affordable, quality PHC services, and particularly on ensuring that disadvantaged groups are reached first. Guaranteed entitlements can expand beyond PHC as fiscal capacity increases. Beyond this overarching principle, the Commission has identified four key attributes of people centred financing for PHC.

First, public resources should provide the core of PHC funding with minimal reliance on direct payments when services are accessed. In most LMICs, this level of public funding can only be generated through increasing allocations to

PHC from general tax revenue. Revenue raising mechanisms should be defined based on ability to pay and be progressive. While each country is at a different starting point for a shift to predominantly public funding, strategic and purposeful change to national health financing systems over time can enable gradual progress. In the meantime, low-income countries will require continued development assistance to secure a sufficient resource envelope to enable population coverage of essential PHC services.

Second, pooling arrangements should cover PHC. By supporting PHC with pooled public funds, out-of-pocket payments can be reduced to levels at which they do not pose financial barriers to accessing needed care, impoverish households, or push households deeper into poverty. Pooling enables cross-subsidy among those who are well and those who are ill, and among the poor and the wealthy.

Third, resources should be allocated equitably across levels of service delivery and geographic areas, and be protected to reach frontline PHC service providers and patients. Resource requirements for PHC should be estimated on the basis of accurate assessments of population health needs. Countries should deploy strategic resource allocation tools (including needs-based per-capita resource allocation formulae) in budget formulation, budget execution, public financial management policies, and service delivery arrangements to channel and protect the flow of resources for PHC.

Fourth, provider payment mechanisms should: assign resources based on people's health needs; create the right incentive environment to promote PHC that is people-centred along the spectrum of prevention, health promotion, and treatment; foster continuity and quality of care; and be flexible enough to respond to changing needs of patients, families and communities. This is best achieved through a blended provider payment system with capitation at its core.

7. ANALYSIS OF HOSPITAL ACTIVITY

The management of the inpatient home is carried out by the head of the medical department of an outpatient clinic or polyclinic as part of a medical institution, in the district hospital, outpatient clinic - the head physician. At the suggestion of local therapists, pediatricians, general practitioners - family doctors, other specialists, he selects patients for treatment in a hospital at home.

All medical institutions regularly submit state statistical reporting forms. The main one is form No. 20 “Report of a medical institution”, which contains a large number of tables with information about:

- medical personnel, departments, preventive examinations, operations performed;
- activities of dispensaries, consultations, polyclinics, a dental office, a hospital;
- number of patients, newborns, people with disabilities.

Assessment of the work of the hospital is based on the analysis of two groups of indicators, one of which characterizes the bed capacity and its use, and the other - the quality of medical diagnostic work.

Analysis of hospital performance is carried out by comparing with similar data on:

- this hospital last year;
- other hospitals or specialized departments;
- region or republic as a whole.

In addition to calculating and analyzing the above indicators, in assessing the work of the hospital, each case is expertly evaluated:

- nosocomial infection;
- death of postoperative complications;
- death after surgery;
- discrepancies in clinical and pathological diagnoses.

The development of a mission is a good reflection of the focus and direction of the hospital’s leaders and leadership, as well as the hospital’s unique history, the hospital’s role in the community, social context, human health orientation, and

expectations of the part of healthcare providers, showing more about social responsibility and sustainability. Furthermore, in the vision of the five hospitals, there is a consensus on the vision of the hospital with a focus on: the equity of patients and staff, the development of staff and even staff leadership, which can help the hospital attract top staff and improve the efficiency and results of hospital management to ensure patient service.

8. TEST QUESTIONS FOR SELF-CONTROL

1. Which of the following does not concern to the main tasks of the admission department (reception)?

A) Examination of work capacity

B) Establishing of the preliminary diagnosis

C) Determination of the profile of specialized department and referral to it

D) Provision of necessary medical care

E) Reception, registration and distribution of the patients entering the hospital

2. The data were obtained about quantity of the patients treated throughout year and mid-annual quantity of beds (cots) at the end of the year in the hospital. Which of indicators can be calculated from these data?

A) Bedspace of the hospital

B) Mid-annual bed occupancy

C) Bed turnover

D) Average duration of stay of patients in a hospital

E) Average duration of idle time of bed

3. To the functional duties of the attending physician are all listed, except:

A) Realization of diagnostics and treatment of patients in a hospital

B) Discharges patients from hospital

C) Realization of examination of temporary incapacity for work

D) Representation of patients to Medical consultative board and Disability Determination Services

E) Dispensary observation of chronic patients

4. According to the report of the hospital the information on quantity of the operated patients and on quantity died after operation was obtained. Which indicator can be calculated from these data?

A) Standardized lethality

B) Postoperative lethality

C) Postoperative death rate

D) Total mortality

E) The Indicator of late hospitalization from the disease beginning

5. The medical documentation of a hospital concern:

A) The case record

B) Statistical record of patient, discharged from hospital

C) Medication administration record

D) All of the above

E) Pathology record

6. According to the annual report of the hospital, information was received on quantity of bed-days and quantity of the patients treated for a year. Which indicator can be calculated on the basis of this data?

A) Average length of stay in a hospital

B) Bed turnover

C) Lethality rate

D) Efficiency of use bedspace

E) Average bed occupancy

7. The medical care provided to patients, whose condition demands round-the-clock surveillance in the conditions of public health services establishment?

A) Medical-diagnostic

B) Stationary

C) Out-patient

D) Preventive

E) Emergency

8. Which of the listed functions of the hospital includes diagnosis and provision of the specialized round-the-clock stationary care in sufficient volume, complex regenerative treatment, and disability examination (working capacity examination)?

A) Preventive

B) Organizational-methodical

C) Therapeutic and recovery

D) Research

E) Educational

9. A ratio of quantity of the bed-days spent by patients to average annual beds is:

A) Completeness of using bedspace

B) Provision of the population hospital cots

C) Load per one doctor position

D) Mid-annual bed occupancy:

E) Bed turnover

10. The measures for rational use bedspace are all, except:

A) Uniform distribution within week of hospitalization and discharge

B) The Organization of a day hospital

C) Diagnostic inspection of the patient in polyclinic

D) The Intensification of diagnostic and medical process

E) Increase of hospital capacity

11. Indications for the referral of the patient to hospitalization include everything, except:

A) The need for long-term treatment

B) Presence of urgent conditions

C) Necessity of carrying out of complex diagnostic manipulations

D) Necessity of application of intensive methods of treatment

E) Inefficiency of out-patient treatment

Keys: 1 - A, 2 - C, 3 - E, 4 - B, 5 - D, 6 - A, 7 - B, 8 - C, 9 - D, 10 - E, 11 - A

9. SITUATIONAL TASK

Task 1. Calculate and evaluate the indicators of performance of an inpatient facility.

Served population amounts to 60 000. Number of beds in the hospital — 400. During the year, 8 600 patients have been admitted, 8 460 have been discharged, including 4 125 recovered, 4 200 improved, 135 without change; 20 have died, and 120 have stayed in the inpatient facility. All the treated individuals have stayed in the hospital for 102 600 bed days. All the deceased have been subjected to autopsy. Clinical diagnosis has been confirmed in 18 patients. Results of diagnosis comparison have been discussed at clinical anatomy conferences. Number of public complaints — 2.

1. Annual average occupancy of a bed:

$$\frac{\text{Number of spent bed days per year}}{\text{Annual average number of beds}} = \_\_\_\_\_ \text{ days.}$$

2. Bed turnover:

$$\frac{\text{Number of patients who have been discharged and those who have died during the year}}{\text{Annual average number of beds}} = \_\_\_\_\_ \text{ times}$$

3. Average duration of stay in the inpatient facility::

$$\frac{\text{Number of spent bed days per year}}{\text{Number of patients who have gone through the inpatient facility (discharged and deceased)}} = \_\_\_\_\_ \text{ days.}$$

4. Share of the patients discharged with recovery:

$$\frac{\text{Number of patients discharged with recovery}}{\text{Number of all discharged patients}} \times 100 = \_\_\_\_\_ \%$$

5. Share of the patients discharged with improvement:

$$\frac{\text{Number of patients discharged with improvement}}{\text{Number of all discharged patients}} \times 100 = \_\_\_\_\_ \%$$

6. Share of the patients discharged without change in health condition:

$$\frac{\text{Number of patients discharged without change in health condition}}{\text{Number of all discharged patients}} \times 100 = \_\_\_\_\_ \%$$

7. Share of clinical and pathoanatomic diagnosis discrepancies (misdiagnosis):

$$\frac{\text{Number of diagnosis discrepancies}}{\text{Number of all pathoanatomic diagnoses}} \times 100 = \_\_\_\_\_ \%$$

8. Hospital lethality:

$$\frac{\text{Number of patients who have died in the inpatient facility}}{\text{Number of patients who have gone through the}} \times 100 = \_\_\_\_\_ \%$$

inpatient facility (discharged and deceased)

NB! Lethality (deadliness) is an indicator calculated as a ratio of the number of deceased due to particular illness and the number of afflicted with this illness.

Lethality should not be confused with mortality, which is a ratio of the number of deceased due to this illness and the average population.

9. Complaints submitted by the population:

$$\frac{\text{Number of complaints}}{\text{Served population}} \times 10\,000 = \_\_\_\_\_ \text{ per } 10\,000$$

Task 2. Calculate and evaluate the indicators of performance of a surgery department.

Surgery department data:						
Number of doctor positions	Number of patients	Number of patients operated upon	Number of patients admitted after 24 hours or more have passed since the diagnosis	Number of patients brought for emergency aid	Number of post-operation complications	Number of people who have died after an operation
15	1 145	487	17	215	14	6

1. ***Average number of operations per one occupied surgeon position:***

$$\frac{\text{Number of operations conducted during the year}}{\text{Number of surgeon positions}} = \_\_\_\_\_ \text{ operations}$$

2. ***Urgency of surgical aid:***

$$\frac{\text{Number of patients admitted to inpatient facility after 24 hours or more have passed since the diagnosis}}{\text{Number of patients brought for emergency aid}} \times 100 = \_\_\_\_\_ \%$$

3. ***Surgical activity:***

$$\frac{\text{Number of patients operated upon}}{\text{Number of patients of the surgery department}} \times 100 = \_\_\_\_\_ \%$$

4. ***Frequency of post-operation complications:***

$$\frac{\text{Number of post-operation complications}}{\text{Number of patients operated upon}} \times 100 = \_\_\_\_\_ \%$$

5. ***Post-operation lethality:***

$$\frac{\text{Number of patients operated upon, who have died}}{\text{Number of patients operated upon}} \times 100 = \_\_\_\_\_ \%$$

Task 3. Calculate and evaluate the indicators of performance of day patient facilities and home care, using the following data.

District	Served population (total)	Including children aged up to 17 years	Day patient facilities			Home care	
			Number of beds	Number of treated patients	Including treated children at the age of up to 17 years	Number of treated patients	Including those with circulatory system diseases
1	88 100	14 700	295	12 000	800	7 324	2 600
2	84 500	11 300	224	10 050	466	5 220	1 900

Day patient facility performance indicators

10.Availability of beds to the population in day patient facilities:

$$\frac{\text{Number of beds in day patient facilities}}{\text{Served population}} \times 10\,000 = \_\_\_\_\_ \text{ per } 10\,000$$

11.Number of treated patients in day patient facilities:

$$\frac{\text{Number of treated patients}}{\text{Served population}} \times 10\,00 = \_\_\_\_\_ ‰$$

12.Number of treated ill children in day patient facilities:

$$\frac{\text{Number of treated ill children}}{\text{Child population (up to 17 years)}} \times 10\,00 = \_\_\_\_\_ ‰$$

Home care performance indicators

1. ***Number of treated patients in home care:***

$$\frac{\text{Number of treated patients}}{\text{Served population}} \times 10\,00 = \_\_\_\_\_ ‰$$

2. ***Structure of treated patients by category of disease:***

$$\frac{\text{Number of treated patients with circulatory system diseases}}{\text{Number of treated patients}} \times 100 = \_\_\_\_\_ \%$$

Appendix 1

Ministry of Health of Ukraine Medical facility name, address _____ Identification code I__I__I__I__I__I__I__I__I__I		MEDICAL RECORDS Form of primary records №003/a **Approved** by the Ministry of Health of Ukraine 26.07.1999 №184

INPATIENT MEDICAL RECORD № _____

Hospitalization									Department _____ ward №____ _____
data	(day, month, year)						(hours, minutes)		Hospitalization for this disease in this year : for the first time – 1, for the second time – 2

The patient spent _____ bed-days. Transferred to the department _____

Blood group _____ Rhesus factor _____RW_____
(day, month, year)

Hypersensitivity or intolerance to the drug _____
(the name of the drug, the nature of side effects)

_____

1. Last name, first name, middle name

_____

2.Gender: mail – 1, female – 2 ☐ 3. Age _____ _____
(day, month, year, children under 1 year – months, children under 1 month - days)

4. Urban resident – 1, or rural resident – 2 ☐ _ Address of the patient: _____
(country, region, street, house, flat)

_____Phone _____

5. Name and address of the place of work, occupation (study, a children's institution)_____

_____

_____

(for the disabled - the type and group of the disability, invalids of war – yes - 1, no - 2 ☐)

6. . Who wrote referral _____
(medical facility name)

7. Terms of hospitalization : emergency hospitalization – 1,(until 6 hours ☐; 7 – 24 hours ☐; later 24 hours.☐) ,planned hospitalization – 2 ☐□

8. Diagnosis of the medical facility that referred the patient: _____

_____

9. Admission diagnosis _____

_____

10. Hospital diagnosis _____

_____

Date of diagnosis:_____ Name of the doctor _____
(signature)

11. Final hospital diagnosis:_____

a) Predominant diagnosis

_____

_____ Cod by ICD-10

_____ 1__1__1__1__1__1

b) Complications

_____

_____

c) Accompanying illnesses

_____

_____

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Електронне навчальне видання комбінованого використання
Можна використовувати в локальному та мережному режимі

Боброва Оксана Вячеславівна
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ОРГАНІЗАЦІЯ ТА ЗМІСТ РОБОТИ СТАЦІОНАРІВ РІЗНИХ РІВНІВ, ОБЛІК І АНАЛІЗ ЇХ ДІЯЛЬНОСТІ. СТАЦІОНАРОЗАМІННІ ФОРМИ НАДАННЯ МЕДИЧНОЇ ДОПОМОГИ

Методичні рекомендації до практичних занять
для здобувачів вищої медичної освіти 3–4 року навчання з дисципліни
«Соціальна медицина, організація охорони здоров'я»

(Англ. мовою)

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