



جامعة الجميع الذكية
EVERYONE'S SMART UNIVERSITY

Everyone's Smart University

Project (Spring 2021)

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Section
Course

Master

(PMG506)

Code
Thursday

Date

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Advanced project Management

Instructions:

- اخر موعد للتسليم هو يوم الخميس 2021-05-08 في تمام الساعة 9 مساءً.
- الإجابة متاحة باللغة الإنجليزية أو اللغة العربية مع مراعاة أن تكون المصطلحات العلمية باللغة الإنجليزية.
- يتم تسليم المشروع في صيغة ملف pdf مع الالتزام نموذج الجامعة ولن تقبل أي مستندات أخرى.
- يجب مراعاة أقسام البحث الرئيسية (مقدمة Introduction، دراسات علمية سابقة Literature Review، طريقة البحث Methodology، النتائج والمناقشة Results and Discussion ، وأخيراً المراجع References . وان كان هناك ملحقات Appendices يتم إضافتها)
- يجب الالتزام بـ Theme موحد كما يلي:
- حجم الخط 12.
- نوع الخط Arial.
- لون الخط أسود.
- المسافة بين الأسطر 1.5 line spacing

• عدد صفحات البحث (لا يقل عن ثلاث صفحات ولا يزيد عن ست صفحات).

Instructor's Name: ~~Eng. Amaal Aburumman~~ **Eng. Dr. Akram M. S. Ali**

Project:

You are required to document your role in administering a project. The project may be set in a business, social, sporting, or family environment but must be of a significant size and scale. If you do not have an actual project to write about you may complete the project hypothetically.

This report will be between three to six pages in length. This is a significant research project.

Your report must address ~~each~~ **ONE** of the following issues:

1. Identify and describe the purpose, scope, and objectives of the project. **Display this information using an appropriate tool.**
2. Describe how the team is given an outline of the project.
3. Describe the strategies that are going to be set up to maintain communication with the team members.
4. Describe the tools that are going to be used to monitor the goals, time frames or milestones.
5. Identify project milestones and activities. **Display this information using an appropriate tool.**
6. Create a budget and link the costs to the key milestones for a project.
7. Describe how you are going to divide tasks and resources amongst a project team. **Display this information using an appropriate tool.**
8. Briefly describe how the progress will be monitored.
9. How are current project records maintained? Who has responsibility for this? provide some recommendations on how this process could be improved.
10. Describe the current procedure for finalizing projects. Create your own procedure and identify how you will evaluate the success of the project.
11. Legislation that may affect the project including health and safety, and anti-discrimination legislation.

Best of luck...

المشروع:

مطلوب منك توثيق دورك في إدارة مشروع. قد يتم تعيين المشروع في بيئة تجارية أو اجتماعية أو رياضية أو عائلية ولكن يجب أن يكون بحجم مناسب. إذا لم يكن لديك مشروع فعلي لتكتب عنه ، فيمكنك إكمال المشروع افتراضياً. ستكون هذا التقرير من ثلاث إلى ست صفحات.

يجب أن يعالج تقريرك ~~كل~~ **احد** القضايا التالية:

1. تحديد ووصف الغرض والنطاق والأهداف من المشروع. اعرض هذه المعلومات باستخدام أداة مناسبة.
2. صف كيف يتم إعطاء الفريق مخططاً تفصيلياً للمشروع.
3. وصف الاستراتيجيات التي سيتم وضعها للحفاظ على التواصل مع أعضاء الفريق.
4. صف الأدوات التي سيتم استخدامها لرصد الأهداف أو الأطر الزمنية أو المعالم.
5. تحديد معالم المشروع والأنشطة. اعرض هذه المعلومات باستخدام أداة مناسبة.
6. إنشاء موازنة وربط التكاليف بالمعالم الرئيسية للمشروع.
7. صف كيف ستقوم بتقسيم المهام والموارد بين فريق المشروع. اعرض هذه المعلومات باستخدام أداة مناسبة.
8. صف بإيجاز كيف سيتم رصد التقدم.
9. كيف يتم الاحتفاظ بسجلات المشروع الحالية؟ من المسؤول عن هذا؟ تقديم بعض التوصيات حول كيفية تحسين هذه العملية.
10. وصف الإجراء الحالي لإنهاء المشاريع. قم بإنشاء الإجراء الخاص بك وحدد كيفية تقييم نجاح المشروع.
11. التشريعات التي قد تؤثر على المشروع بما في ذلك الصحة والسلامة ، وتشريعات مكافحة التمييز.

مع تمنياتي بالتوفيق..

Management of medical records in the hospital

Introduction:

Medical records are a written collection of knowledge of medical history that is essential to maintaining patients' treatment today and in the future.

The information contained in the medical history is used as a valuable medical research tool and as a primary source in the statistics required in the field of healthcare in the advancement and evaluation of treatment in the primary care facility. Doctors, nurses, and other medical professionals may use the knowledge to set a patient's priorities. As previously mentioned, providing and maintaining a medical history in healthcare is one of the goals of medical records personnel to protect patient information during their visits to healthcare centers. Lack of information increases patient suffering due to lack of prior information, which can be vital to ongoing care. Also, the lack or lack of medical records makes the medical record system incomplete and does not properly fulfill the purpose for which it was established, thus affecting confidence in the primary health care business.

What is the medical record?

The medical record mainly contains a list of health records. You already have a basic personal health record form whether you have a registration record or a physical record. You might run into a big problem with authentication: When you need it, you'll never get it. However, Electronic Personal Health Records (PHRs) address this issue by allowing registration information to be viewed on laptops, smartphones, and tablets connected to the Internet at any time.

The medical record is a multifunctional database used by healthcare practitioners to share and document valuable facts about a patient's medical treatment. A complete and accurate assessment of appointments, patient performance, and potential recovery arrangements are the foundation for consistency and reliability of patient hospital and follow-up visits. While medical records are important to patient quality and appropriate treatment, the management of medical records in developing countries is of particular importance.

What is medical records management?

Medical records management is the science of handling all documents related to the management of a healthcare practice. Maintaining and preserving patient maps, sterilizing medical records, ensuring compliance with legislation and retention schedules, and overseeing the destruction of medical records after their retention time is part of the job. Non-clinical activities and details, such as financial reports, contracts, and other work-related documents, are often effectively managed by the Medical Records Administration. Our programs excel in supporting all categories of hospitals, including skilled nursing facilities (SNF) and long-term care facilities (LTCF).

Health record should include any information that helps you and your doctor deal with your health condition, starting with the basics:

- Your doctors' names and phone numbers
- Allergies, including allergies to medicines
- Medicines that you take, including the doses
- A list of the diseases and surgeries you underwent and the history of each
- Chronic health problems, such as high blood pressure
- Living wills and advance directives
- Family history
- History of vaccination

You can also add information about what you do to stay healthy and prevent disease, such as:

- Blood pressure readings at home
- Aerobic exercise and eating habits
- Set healthy goals to achieve, such as quitting smoking or losing weight

Medical records sheet requires multiple personnel to process and organize medical files; this is due to the myriad of medical files and unlike electronic medical records that require fewer people, less time and space, and the enormous costs involved. Paper medical records are stored in large warehouses in a special department, and these files occupy large areas, and thus less are environmentally friendly, use more resources, and paper medical records are more vulnerable to corruption than electronic medical records.

Usually health care providers keep one copies of the medical records on paper, which means lose one medical record means losing the record forever, otherwise the medical records paper is vulnerable to being hacked, and you may also be liable to lose them from an employee or suffer from any disaster such as fire. Or a flood. And requesting a medical records sheet from a doctor such as a care by fax, email or scanning, can take longer.

Literature review:

First study:

Author information:

Regenstrief Institute, Inc., Indianapolis, IN,

2Indiana University School of Medicine, Indianapolis, IN;

4Center for Implementing Evidence-based Practice, Roudebush VA, Medical Center, Indianapolis, IN

Title:

OpenMRS, a Global Medical Records System Collaborative: Factors Influencing Successful Implementation

Methodology:

Data collection

This process began with reviewing the existing data and planning in multiple ways, both qualitative and quantitatively, to collect data to answer the study objectives. Initially,

targeted sampling was used, specifically selecting individuals from organizations that developers knew had implemented OpenMRS. In this sample, we collected data using both the randomized methods and the principal informant. The reason for this data collection approach specifically stems from concerns about accessibility to the study population. Challenges to accessibility include a lack of information about implementation sites, the global community, and resource limitations.

Result:

A total of 10 sites participated, representing 7 countries. Site sizes ranged from large (95,000 patients) to small (450 patients). They had a mix of users (ranging from 3 to over 350) including clinical staff (60%) and non-medical personnel such as data entry clerks (100%). The most common tasks performed by users were data entry and data reporting. Others included patient care, system maintenance, data export, model development, data quality and accuracy review, clinical summaries, alerts, clinical laboratory management, and patient registration.

Second study:

Author information:

aKvalis project, Department of Physiology and Biomedical Engineering, Faculty of Medicine, NTNU, Trondheim, Norway, bKvalis project, Department of Computer and Information Science, Faculty of Physics, Informatics, and Mathematics,

Title:

Doctors' use of electronic medical records systems in hospitals: cross sectional survey

Goals

To compare the use of three systems of electronic medical records by doctors in Norwegian public hospitals and clinical tasks.

Methods:

Collecting information by means of a questionnaire. Semi-structured telephone interviews with key IT personnel in each hospital to obtain local system implementation details

Result:

Most of the tasks listed in the questionnaire (15/23) generally cover jobs that are performed in electronic medical record systems. However, systems were used for only tasks 2-7 and mainly concerned reading patient data. Participants showed statistically significant differences in the frequency of using different regimens for four tasks that provided equal work regimens. The respondents scored high in computer literacy (72.2 / 100), and computer use showed no correlation with the subjects' age, gender, or position at work. User satisfaction scores were generally positive (67.2 / 100), with some differences between systems.

Methodology:

The study used a case study research design. Systematic triangulation of both quantitative and qualitative data a combination method, the Mixed Research Method (MMR), was adopted, which includes more than one mixed or complementary approach. For the purposes of this study, the researcher used multiple methods, which is a method through triangulation of the quantitative approach with little qualitative data in the methodological stage while collecting, analyzing, and interpreting data to confirm the quantitative results. It is a semi-structured questionnaire and semi-structured interviews and notes. Several records management researchers such as Abankwa (1999), Kemoni (1999), Mampe (2013), Thanye (2014), Moatlhodi (2014) and Luthuli (2017) have used the case study method to study records management in the public sector.

There are a number of reasons that can be attributed to the use of the case study approach. Kumar (2008) suggests that a case study allows for the study of a single phenomenon, which puts the researcher in a better position to understand the complex macro world of regulatory actions as they occur. So the researcher is able to understand how people work together in an organization and how their relationships

affect their work. Moreover, the case study provides a deeper understanding of the factors that influence events, changes, and growth within the organization (Rubin 2000, Mampe 2013, Taney 2014, Luthuli 2017). A case study has the advantage of allowing researchers to discover a complex set of decisions and report on the impacts of decisions over time, making it suitable for this research. In this study, the target group consisted of forty-eight records therapists (physician, nurse), and twenty-four medical records managers / clerks. Fifty patients. Of these, a total of 42 registration processors answered the questionnaire. Patients in the general sample were sampled from the hospital conveniently upon admission to the hospital and twenty of them were selected and interviewed. In addition, twenty-two people (Medical Records Clerk and Director) were interviewed. Data from the interviews were disaggregated by topic and the qualitative narrative provided. Some basic quantitative descriptive analyzes were performed using the Google Forms software.

Results and discussions:

Adherence to the procedures and tools compatible with providing the service:

In this study, records processors were asked whether they believed in managing records in their departments with the help of service delivery. Moreover, the patients were interviewed to see if they were happy with the service provided to them by the hospital. Ngelsana General Hospital registrars reported that existing record management tools and procedures helped deliver health services, although the manual system was time-consuming and tedious. They reported under staffing, making it difficult to provide good records management for a quality health service to the community. The researchers pointed out that only two people were working at one time to serve many hospital workers. Many patients make it difficult for just two employees to serve everyone waiting in the queue. The records wizard confirmed this hurdle upon meeting him. He also expressed concern about the medical staff's movements.

Files: When doctors request a file, we number the entire file, so you don't lose any pages. Then again when the doctor finishes the file, we check that not all files are lost. [Whenever the appointment is created, we request this specific file. It could be from our file room and waiting for the file for a long time.

Assistance required from the Patient Records Management Unit:

Records Management Unit (RMU) is the "face" of the hospital. This is where the first visit begins and the hospital service classification begins. Users were asked how long it took to get the help they were looking for from RMU. The follower said four of the respondents answered this question, four said it took days, thirteen said it took hours, and only three said it took minutes. During the interview, some patients indicated that sometimes three to four hours pass without any help.

Location and time period for retrieving medical records:

This study sought to determine the frequency of records creation and use. Record users were asked to indicate how often the requested records would be duplicated.

Registration processors were asked to indicate what happens when a patient's file is not in its normal location. Record processors indicated that for purposes of continuing a patient's health record, if the patient's files are not found, duplicate copies of records are made. Patients agree to create a new device registry when an old device cannot be found.

Patient satisfaction with records management in a general hospital:

The majority of respondents from Nguelsana Hospital said that they are dissatisfied with the way their records are managed in the outpatient department (outpatient clinics) the outpatient clinics are responsible for all files in the hospital as the records are managed by clerks. The study revealed that patients found their files covered in dust or torn apart. Sometimes, entire papers or files are lost and patients are not informed of their whereabouts.

Impact of records management structure on service delivery:

Records processors were asked to indicate the type of records management system the hospital has adopted. There the discrepancy in the responses was that five record processors and medical personnel confirmed the use of a centralized records management system, 63 of whom said they used a decentralized system; while twenty were not sure of the use of the system.

Recommendations:

- There is a need to practice ICT or electronic records management and the need to move away from the usual practice of manual record management to ensure easy and rapid access to the storage, retrieval, and security of patient records.
- To strengthen records management practice, there is a need to involve professionally qualified health information personnel and vital statisticians as is the case in all health facilities.

Health facilities should provide records management personnel with training, courses, and workshops to cover professional digital or electronic records management capabilities.

- The privacy and confidentiality of patient health records must be promoted and fully respected by all.
- The patient's right to obtain complete information about his or her condition and its management is guaranteed.

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