Discuss in brief about work order management.

4. Why do you mean by equipment control and asset management?

3. Write in brief about the hospital services.

2. State the types, objectives and functions of OPD services in hospitals.

1. What happens in the front office in the hospitals?

Answer any FIVE questions.

PART A — (5 x 6 = 30 marks)

Maximum: 100 marks

Time: Three hours

(2013-14 Batch onwards)

HOSPITAL OPERATIONS MANAGEMENT

Hospital Management

Third Semester

DECEMBER 2014/ JANUARY 2015

M.B.A. DEGREE EXAMINATION

MBM 3004
6. What do you know about patient safety in hospital administration?

7. Write in brief about radiology and radiography.

8. Discuss in brief about Death in Hospital.

   PART B — (5 × 10 = 50 marks)

   Answer any FIVE questions.

9. Discuss in detail about the necessities of hospitals.

10. State the uses of X-rays.

11. Explain in brief about data quality management.

12. Discuss about the personal management in hospitals.

13. Discuss about the duties and responsibilities of biomedical engineer.

14. Explain about the ambulance Services.

15. Write in detail about health care technology management.

16. Describe the medical laboratories of health care.
John T. James, Ph.D., who oversees the advocacy

Disease Control and Prevention studies. The latest findings are based on research conducted by centers for Disease Control and Prevention, according to Centers for Disease and Cancer. The third leading cause of death behind heart disease and cancer would make medical errors hospitals. Those figures would make medical errors at a rate of 210,000-400,000 patients who seek care at a hospital. The new study reveals that each year, preventable medical errors lead to the death of up to 98,000 people, which is roughly the same number as the number of patients who die in hospitals each year due to hospital mistakes. The data for that report is based on medical record reviews from 1984 and 2008. doesn’t take into account studies published since then.

Building a Safer Health System, which estimated the Journal of Patient Safety, the latest numbers are dramatically higher than those in the Institute of Medicine’s 1999 report. To Dr. is Human: "Medicine is more complex now, which leads to more mistakes. "Building the statement of 400,000 deaths a year. According to a new study in the Journal of Patient Safety, the latest numbers are higher than previously thought, and may be as high as 400,000 deaths a year. Medical errors lead to patient death are much higher than previously thought, and may be as high as 400,000 deaths a year. Medical errors lead to patient death are much higher.

Case Study: Compliatory

PART C — (1 x 20 = 20 marks)
group Patient Safety America, an organization he founded in honor of his 19-year-old son who died in 2002 as the result of what he describes as negligent hospital care.

James analyzed four recent studies that used the "Global Trigger Tool" to flag specific evidence in medical errors, such as medication stop orders or abnormal laboratory results, which point to an adverse event that may have harmed a patient. A physician must concur on these adverse event findings before they classify the severity of patient harm. Based on the weighted average of the four studies, he concluded that at least 210,000 deaths are due to preventable harm in hospitals. But because of the Limitations of the tool and incomplete medical records, he wrote that the number is likely twice that figure, more than 400,000 deaths each year. "There was much debate after the IOM report about the accuracy of its estimates," James wrote in the study. 'In a sense, it does not matter whether the deaths of 100,000, 200,000 or 400,000 Americans each year are associated with PAEs in hospitals. Any of the estimates demands assertive action on the part of providers, legislators and people who will one day become patients. "The problem, James said, is that action and progress on patient safety has been slow. He wrote that he hoped these latest evidence-based estimates of 400,000 patient deaths each year will foster an "outcry for overdue changes and increased vigilance in medical care to address the problem of harm to patients who come to a hospital seeking only to be healed."

Lucian Leape, M.D., who served on the committee that wrote the "To Err Is Human Report," told ProPublica that he believes James' estimate is accurate. He said the committee knew at the time of its 1999 study that the numbers were low. "It was based on a rather crude method compared to what we do now," Leape told ProPublica. Furthermore, he said, medicine is more complex now, which leads to more mistakes.