МЕДИЦИНСКИЕ НАУКИ

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PROBLEMS RELATED TO MEDICAL DOCUMENTATION IN MEDICAL STRUCTURES

Abstract. Medical documentation tracks the patient's path during the diagnostic and treatment process and recreates in writing all the services rendered, therapeutic and diagnostic procedures. A visual representation of the data allows you to track changes in the patient's condition and therapeutic response to treatment. It is essential that everything is documented and supported by materials (research, protocols, photos, dependencies, records, etc.). Primary medical documents are subject to regulatory requirements. Proper replenishment guarantees adequate treatment and care. Creating documents with different content leads to moral and legal consequences, which also affect the adequacy of the treatment and the desired effect.

The General law regulating the collection and processing of medical information for citizens is the Health law. According to him, health information is personal data related to the state of health, physical and mental development of people, as well as any other information contained in medical prescriptions, prescriptions, protocols, certificates and other medical documentation. The preparation of individual medical documents is regulated by the National framework agreement on medical activities for medical care contractors(hospital and outpatient). According To the law on the protection of personal data information from the medical records of individuals is protected personal data.

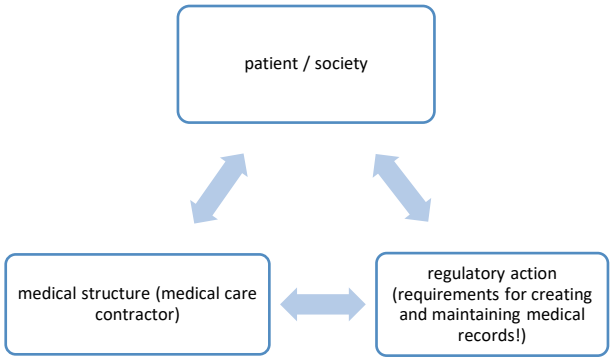
The Health law defines the circle of persons who have the right to process personal data of citizens related to their health status. These are medical and medical institutions, competent state authorities in the field of health and medical insurance, as well as relevant medical specialists.

The processing, use and storage of unidentified details of the individual medical data and the exchange of medical and statistical information is carried out in accordance with the regulations of the Minister of health, agreed with the National statistical Institute.

Keywords: medical data, documents, hospital, regulations, responsibilities.

Introduction: Medical professionals have legal grounds for collecting and processing "confidential" personal data [6]. They collect medical history, check and record results and symptoms, conduct research, and save the results. The concepts of medical or medical dossier are used both for the physical carrier of information and for the information itself contained on a specific carrier [5]. The information contained in medical records allows medical service contractors to quickly learn the patient's medical history in order to be informed when making decisions about performing the necessary medical measures [5]. A medical document (cardboard, medical History, etc.) is an information source for planning patient care and documenting the relationship between the patient and the contractor of health care and service activities. The medical dossier is intended to ensure that the documentation complies with institutional, professional or legal regulations in the field of health care. A medical document has legal significance and represents the chronological history of the disease (diagnosis, treatment, care, etc.) of each individual patient [3,4]. Medical documentation is a document that directly connects the patient with the activities performed and care for their health condition [7]. Every medical professional must know the relevant medical documents and training forms and be able to fill them out properly, clearly and legibly, with facts and reliable information. Confidentiality is a condition that accompanies the workflow and relationships with colleagues and patients [1,2].

Exposure: In medical institutions, all medical and non-medical activities carried out during the treatment and diagnostic process are recorded qualitatively and quantitatively, through special reporting documents that are regulated by the relevant laws and acts of the Ministry of health. They reflect information about the health of the patient, the user of medical services. under article. 27, paragraph 1 of The Health law: "Health information is personal data related to the state of health, physical and mental development of people, as well as any other information contained in medical prescriptions, prescriptions, protocols, certificates and other medical documentation."Regulatory requirements are regulated in laws and regulations (the law on health, in regulations confirming medical standards) and internal regulatory rules, precepts and guidelines (Rules of the device, activity and internal order of the medical institution, Rules of document management circulation, orders and instructions) (Fig.1). In The Health law, all medical events are registered qualitatively and quantitatively in special accounting and reporting forms. They are mandatory and the same for all medical institutions. You must fill in clearly, accurately, legibly, and grammatically correct. Medical personnel are required to know well all forms of training that they use in their work and to conduct them in good faith.



Rice.1. Patient relationship-health services-regulatory requirements.

The creation of medical documentation is carried out in accordance with the requirements for the medical care contractor and the coverage of medical services provided. This requires a preliminary explanation to the consumer (patient) of the need to collect health information related to their condition through the point. grenade. informed consent. Informed consent sets the scope for non-medical activities that medical professionals can perform after the patient's prior consent. Medical documents that are created by the primary and subsequent, for different depending on the scope of services performed. The main medical documents created in hospital structures can be classified by their nature: normative and internally institutional, as well as General and specific:

I. 1. Normative: These are the laws, regulations, medical standards, Guidelines and regulations of the Ministry of health; and the national framework agreement on medical activities.

2. Internal institutional: rules for the organization, operation, and internal order of the hospital / and individual structures; rules for coordination between structures; rules for document flow of documentation; rules for personal data protection; rules for the activities of hospital commissions created by order of the Manager / Board of Directors;

II. ***General:*** 1. Medical history (MH) - a document that gives a complete picture of the development of the disease, the treatment and diagnostic process, the outcome of the disease of each patient taken for inpatient treatment. Everyone who is related to the patient should document the course of the medical activities carried out.

MH consists of several parts that give an idea of the patient (passport part-names, years, gender, physique, etc.), his condition at his admission, about the factors related to his disease-symptoms and complaints. Every day needs to be filled: Decurso Morbi (disease development). The results of all conducted studies are noted in the MH, such as study omissions attached to the MH. All medical professionals (doctors/ health professionals) who are involved in the provision of medical and diagnostic interventions should be well aware of this document, as they use it for references on appointments, research, diet, regimen, consultations, etc. responsible persons are appointed by order to maintain good order and appearance.

2. Temperature sheet-filled in for each patient and recorded three names, age, address, date of admission, day of illness, number MH. In it, it graphically notes the patient's temperature, pulse, and breathing; digital diuresis, specific gravity of urine, blood pressure, and body weight (with certain signs). The regime, diet, therapy, and Some studies are applied. Thus, the filled, temperature sheet is an important component of the MH. It serves medical professionals for reference and checking doctor's appointments.

3. Epicriz-reduced information about all data from the MH prepared at the exit, when the patient is discharged/ transferred to another structure (stage or final).

4. Medicine plate-consists of medication sheets (recipes) that are used only in the hospital. They were collected in a scroll, numbered, prosciutto, and stamped from the hospital. All medications and supplies for the Department are provided through it. This is a financial report document filled in in 2 or 3 copies. It is filled in grammatically correctly, in Latin, they are entered-compartment, date, room number and bed, three names of the patient, his age, the MH and all prescribed medications from the attending physician. Passes must be clear and legible. Special attention is paid to the dosage of drugs. A sign with the medication signed by the doctor and a specialist in the field of health (nurse/ midwife).

5. The book about accepted patients (General hospital and individual structures) - is filled in the receiving and diagnostic unit and takes into account the movement of patients in structures/ departments. It contains three names of each patient, information about their age, home address, diagnosis, when they were admitted, when they were discharged, how many patients they have, and much more.

6. Report book-serves for transferring and receiving patients from one team to another. It is maintained for day and night duty. It reflects everything that happened while on duty. In it, health care professionals send names for observation of seriously ill patients, additional appointments, preparation for research, reflect changes in the condition of patients, data on their movement (reception, discharge, translation). This Book is an important document that reflects not only the condition of patients, but also the work of day and night shift specialists on duty. You must behave carefully, clearly and accurately.

7. Patient movement list-reflects changes in the number of patients per day-received, transferred, discharged, deceased, and the number of available seats. In it, accepted and discharged patients are marked with three names, room and bed numbers, a diagnosis, for those transferred – and in which Department they are transferred. The deceased are listed by three names, a diagnosis, and the exact time of death. Information is required for statistics.

8. The bypass notebook is maintained daily. Appointments for a particular patient are marked, medications, diets, and diet. Based on appointments, a healthcare professional can develop a care / midwifery plan for any patient. The notebook is modeled.

9. A notebook for manipulations and procedures-it is kept in departments, in manipulation and dressing rooms, diagnostic and Advisory offices of hospital structures. It is noted that a specific patient was committed (injections, washing, bandages).

10. Slotted sheet-represents a request from the Department to the nutritional supply unit of patients, while noting the number of patients and the number of diets. Diets are determined by the patient's condition in accordance with his illness.

Specific: 1. The intensive care sheet is for the seriously ill sectors and branches of intensive therapy. According to the doctor's prescription, it can be noted at certain hours (half an hour, one or two hours, etc.) vital signs (pulse, breathing, temperature, blood pressure, water balance), therapy, regime, diet. The number of infusions and secreted fluids is noted. It is stored in the repository at the MH.

2. Pre-anaesthetic consultation sheet - the anaesthetic risk class of Asa is determined (in points), through a patient questionnaire and a physical examination by a specialist doctor.

3. Anesthetic list-performed in operating structures, during surgical interventions, indicating the conduct of anesthesia, participants, used drugs and infusion solutions.

4. Preoperative epicrisis sheet - having the task to briefly present the problems that led to the need for surgical intervention, problems that increase the operational risk, its assessment and recommendations for the upcoming operation.

5. Operational Protocol-reflects in detail the performed surgical intervention-date, patient names, indications, operation progress, blood loss, complications, involved medical specialists, comments and appointments.

6. Various protocols and slides for analysis of blood, urine, sputum, etc.; x-ray studies, ultrasound studies; records-cardiographic (ECG), cardiotocographic (nst), dopplers, etc.

7. Declaration of payment, according to the decree on the exercise of the right to access medical care of the Ministry of health, resolution 2 of March 27, 2019. for medical and other services, article 82, paragraph 1 and 3 of the health Act and the terms of their approval, use and payment, etc.

8. Informed consent for various medical and diagnostic interventions that clearly and in detail describe the possible benefits, risks, complications and emerging risks for the patient and his condition.

9. Other: a quick notice about a communicable infection.; Birth report; perinatal death Report; death Report; Specific records and reporting forms.

Problems: 1. The problems that accompany the creation of medical documentation are directly dependent on the patient's condition, the urgency of his service, the knowledge and skills of medical specialists, the readiness of the structure to provide appropriate medical care or service, and so on.the Regulatory requirement is timely and correct for filling out medical documentation in chronological order. However, in emergency, life-saving situations, this is completely impossible, because as the efforts of all doctors are aimed at saving human life, at mastering the life-threatening condition, as well as at improving the patient's condition. Subsequent filling out of the documentation hides the risks of inaccurate and incomplete identification of the medical and diagnostic measures taken. Documentation must be correct and legible so that it can be properly understood and lead to concrete actions aimed at improving the patient's condition.

2. The introduction of the regulation year (EU) 2016/679 of 25.05.2018 from 27.04.2016-the General data protection regulation (GDP) has had an impact on the work of medical institutions, so the lack of specific recommendations for its application in the field of health has proved to be a serious deficit to this day. The European hospital and the health Federation have come up with recommendations to member States regarding the application of the rule, the most important of which is "providing hospitals and other health facilities and organizations with sector-specific advice and recommendations, as well as training of the national governing body that is necessary to demonstrate compliance with regulatory requirements"). According to the regulations, medical institutions process a certain category of data that is perceived as confidential personal data, so processing is allowed under certain rules. Patients have the right to information and consent regarding the processing of personal data: data that identifies them and contact data for the purposes of processing for which the personal data is intended, as well as the legal grounds for their processing. Users of medical activities and services should also be informed about how to exercise their individual rights: for example, how they can request that their personal data be corrected or deleted; how informed consent can be revoked; and how to file complaints. The right of a patient to "be forgotten" will create many problems related to tracking their status and condition. Data on patient records, records, etc. are stored in the structures of their creation and consumed for the purposes of statistics and other regulatory authorities. Confrontation occurs if the patient wants to be forgotten, over time, for some reason, a check is appointed through the control body, and by law, the documentation is stored for at least 50 years. (then it is destroyed-in the appropriate order / transferred to the State archive). Unlike some other sectors where the

right to be forgotten will often apply, in health care it will be difficult for the patient to have this option. There is a serious misconception that patients can tell a medical institution that they want to delete their data and make it possible. Thus, if the patient is being examined, it is necessary to constantly monitor him, so his personal data can not be simply deleted. The regulation applies to national framework contracts and their annexes, medical standards, the health act, the health insurance act, and numerous regulations. The absence of e-health and the maintenance of a huge amount of paper documentation creates additional risks for its correct and legal processing.

3. Hospitals maintain an extremely large amount of paper documentation. The real challenge is to create and implement algorithms to ensure compliance. The regulatory requirement is to draw up a list of cases with retention periods for each medical and non-medical document created on the territory of the structures of the medical institution. It guarantees and classifies documentation and determines how long it can be stored, accessed, and how it can be transferred or destroyed. It is important to organize timely digitization of medical records, such as technical implementation, in accordance with regulatory sustainability for fully electronic documents. Unstructured data (word, superiority, FDF personal data files) is a serious problem and does not guarantee security. There are almost no such documents to protect yourself in a normal window environment, unfortunately, such data remains "alive" even when the computer is damaged. It is very important to draw:

- objective risk assessment based on: 1. the nature, range, context, and purpose of processing; 2. possible risks to the rights and freedoms of individuals and their probability and severity; 3. consequences for the rights and freedoms of persons with access to specific medical information;

- internal instructions / rules / procedures/ - privacy Policy in the relevant medical institution.

It is necessary to take the problem seriously: identify employees or a team in the medical institution that will be responsible for bringing the activities of the medical institution-the administrator of personal data in accordance with the new regulatory requirements in the field of personal data protection. Must know: regulation 2016/679 (General data protection regulation), The law on the protection of personal data and regulations on its application, the guidelines and guidelines of the working group on article 29 (after 25.05.2018-the European data protection Committee) and The Commission for the protection of personal data. It is necessary to work on creating and regularly updating internal registers of personal data processing activities in a medical institution.

4. The health law lists cases where health information can only be provided to third parties by exception. These are cases where there is a threat to the health or life of other people, or it is necessary to identify the human body or to determine the cause of death. The law on health pays special attention to the right to protect personal data related to the state of health of people. The patient has the right to have full access to health information related to them, including copies of their medical documents. At the death of a patient, his heirs and relatives by rights and by conditional line up to the fourth degree, among other things, have the right to get acquainted with his medical information, as well as to make copies of his medical documents. Violation of these obligations entails appropriate sanctions. In case of violation of any of these rights, citizens have the right to apply to the General procedure of the Commission for the protection of personal data or to claim their rights directly to the court.

5. Conscious or unconscious disclosure of facts and data about the treatment process by employees or patients themselves. The code of professional ethics regulates strict compliance with the confidentiality of information that has become available to any medical or non-medical person during treatment and diagnostic activities. Each medical profession has its own ethical standards, which it is obliged to observe when carrying out its profession. Any ad that goes beyond the scope of health care provided is subject to sanctions.

6. In accordance with the law on personal data protection and the General data protection regulations, any individual who believes that their right to protect their personal data in a medical facility has been violated can file a complaint with: the hospital itself; the personal data protection Commission or other Supervisory authority. Despite the well-regulated relationship between the hospital and patients, they respect complaints to control institutions about: lack of sufficient awareness; dissatisfied with medical care

Conclusion: medical documentation and all the specific documents available in it give an idea of the patient's path in the medical structure, the course of the disease, and the medical and diagnostic measures carried out. Of paramount importance is the professional qualification of a medical specialist and their knowledge of how to create medical documents. Correct filling in requires responsibility, accuracy, and attitude to the workflow, since both the patient and all medical professionals are active participants in the process of providing and requiring medical and diagnostic procedures. Problems in the workplace arise because of the workload and urgency of medical care, the commitment of specialists to care for patients. It is very important that employees are trained in novelties and regulatory requirements on how to work and store medical information. It is necessary to know the organization of work, features of the working process and regulatory requirements for the preparation of medical documents at any time from the patient's stay. Timely organizational and technical measures must be taken to demonstrate compliance with regulatory requirements(General and internal institutional), regulations that will include staff training, internal audits, and updating internal rules and standards that are still in effect. One of the most important measures in the field of health care is to explain the importance of protecting confidential personal data and treating it responsibly. It is necessary to apply ethical rules and

observe good clinical practice in one when providing medical services throughout the patient's journey To and from the healing structure.

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MODERN METHOD FOR THE ASSESSMENT OF THE STRUCTURAL CHANGES IN THE MAJOR SALIVARY GLANDS

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СОВРЕМЕННЫЙ МЕТОД ОЦЕНКИ СТРУКТУРНЫХ ИЗМЕНЕНИЙ БОЛЬШИХ СЛЮННЫХ ЖЕЛЕЗ

Abstract. Changes in the parenchyma and ducts of the major salivary glands in case of the Sjogren's syndrome are detected by the contrast-enhanced sialography. However, its performance requires the intraductal administration of the iodine-containing radiopaque agent, which is contraindicative for patients with the iodine allergy and is not advisable in case of the thyroid gland pathology.