PRACTICAL 12 MAINTENANCE OF RECORDS

Structure

12.0 Objectives
12.1 Introduction
12.2 Purposes of Patient’s/Client’s Records
12.3 Types of Records
   12.3.1 Medical Records
   12.3.2 Hospital Records
12.4 Guidelines While Recording
   12.4.1 General Guidelines
   12.4.2 Specific Guidelines
12.5 Care of Records
12.6 Let Us Sum Up

12.0 OBJECTIVES

After completing this practical, you will be able to:

- explain the purpose of patient’s/client records;
- identify types of records and information, required for recording;
- use records in giving care to patients/clients;
- follow general and specific guidelines while recording;
- use commonly used terms and abbreviations while recording; and
- take care of records.

12.1 INTRODUCTION

So far you have learnt about the skills needed to perform various procedures in care of sick child. The care which you provide is complete only if you record what you have done. You will agree that records are eyes and ears of nurses and health care team members. The maintenance of records becomes an integral part of health care. Records are backbone of patient/client care in the hospitals and community. Recorded facts have a value and scientific accuracy for more than mere impression of memory and there are guidelines for better patient/client care. They help to plan the next steps to be taken to meet individual needs of patients/clients. Each record is important in relation to achieving objectives of health care and nursing care and this is true also in the paediatric age group clients.

How can you participate in maintenance of records of clients of paediatric age group? What informations you need in records? How can you maintain records? All these questions will be dealt within this section.
12.2 PURPOSES OF PATIENT’S/CLIENT’S RECORDS

Following purposes are served by maintaining patient’s/client’s records:

- A means of communication.
- A basis on which therapy is prescribed.
- An aid to physician in diagnosis.
- An aid to nurses to prepare nursing care plan.
- Guidance of continuance.
- Material for education and research.
- A legal document admissible in courts as evidence.

12.3 TYPES OF RECORDS

As you know there are various types of records maintained in the paediatric units. They are as follows:

12.3.1 Medical Records

This includes:

- health history of patient/client
- a report of the findings on examination
- signs and symptoms
- observation records
- progress notes
- discharge summary
- instruction to be followed at home

The following items are included in patient’s/client’s record:

- identification data
- complaint, reason for seeking medical aid
- present illness
- past history
- family history
- physical examination
- special examinations
- provisional and final diagnosis
treatment medical/surgical
pathologist’s report
progress notes
condition on discharge
follow-up records
autopsy findings
day to day nurses notes

12.3.2 Hospital Records

These contain following records:

- Graphic chart of temperature, pulse respiration, blood pressure, number of bowel evacuations, volume of fluid intake and output.
- Orders for treatment written by the physician.
- Reports of laboratory findings and special examinations.
- Reports of anesthesia, operation, physical therapy, occupational therapy, social service, any special treatment.
- Statistical and social data.
- Nurses notes.

We shall elaborate on nurses notes.

There is wide variation in nurses record and in some hospitals, these notes are always filled for permanent reference with the remainder of the records. These notes should be written by nurses and it will help in providing care to the patients/clients.

Generally, the nurses’ notes serve as a record and covers five categories of information:

- Therapeutic measures carried out by various members of health team.
- Measures ordered by the physician and carried out by nursing personnel.
- Nursing measures which are not ordered by the physician but which the nurse carries out to meet the specific needs of a patient/client.
- Behaviour and other observations of the patient which are considered to be pertinent to his/her general health.
- Specific responses of the patient to therapy and care.

The following format may be used in writing nurses notes:

Name of Hospital:

Name of Patient:

In Patient No.:
Activity 1

i) Select one patient of a paediatric age group.

ii) Collect the patient's file with all records.

iii) Write down in the following box the type of record and purpose.

iv) Prepare a nursing care plan for the patient and maintain nurses notes as prescribed in the format, for five days and discuss with the sister-in-charge of the ward.

<table>
<thead>
<tr>
<th>Sl. No.</th>
<th>Type of Record</th>
<th>Purpose</th>
</tr>
</thead>
</table>

12.4 GUIDELINES WHILE RECORDING

When you maintain record of a client in hospital or a community you have to follow some set guidelines. These may be specific or general as given below:

12.4.1 General Guidelines

While working in the ward, you are always required to record. You should follow the general guidelines while recording which are as follows:

- All entries on the chart must be accurate and factual.
- Exactness is essential in changing times, effects and result of treatments and procedures.
- Full dates including year should be written.
- Use ink while entering and write legibly.
- Each entry must follow by your first initial, last name and title.
- Ditto mark and erasers are not acceptable. Errors are corrected by drawing a single line through the incorrect material and writing in the correct entry as close to the mistaken entry as possible.
- Lines should not be left completely or partially blank in the record. If a line is skipped or not filled completely, draw a single line through the remainder to prevent charting by someone else.

- Descriptions are essential when charting about drainage, stool, vomitus, pain and any other diagnostically valuable occurrence.

- The time should be recorded on all entries.

- Only abbreviations accepted by the hospital are allowed on the record.

- Each page of the chart must be identified with the name of the patient/client, hospital identification number and any other data required by the hospital.

- The reliance on various facilities as a means to reimbursement for health care facilities had placed increased emphasis on the need for accurate documentation.

- The chart should reflect nursing assessment and nursing therapy prescribed by the professional registered nurse and reflected on the nursing care plan.

12.4.2 Specific Guidelines

- Physician’s orders
  - Each order should have the date and time it was written.
  - Some way of indicating which orders have been carried out is necessary.
  - The professional nurse who assumes responsibility for noting the order must sign time, name and title to verify notation of the orders.

- Graphic records, treatments and procedure sheets
  - Graphic records for temperature, pulse and blood pressure must reflect accurately the client’s actual vital signs.
  - Discrepancies such as elevated temperature or abnormally depressed pulse should be reported to the senior nurse or physician responsible for the patient’s/client’s care.
  - All treatments and procedures must have the time at which they occurred.
  - There should be place to chart the patient’s/client’s response, untoward side effect and result.

12.5 CARE OF RECORDS

Patient’s/client’s records are unquestionably valuable documents. These should be made on paper of good quality and protected from soiling, and burning. These must be preserved in a special file and kept in a special rack on wheel or hung in a chart room near the head nurse’s station. These records must not be handled by patient’s relatives and non-medical personnel. The recording should be done with care to prevent waterdrops falling on the records. All records of the patient/client be sent to medical record section after the discharge.

Activity 2

In your ward, find out where the records of the patients are kept and how they are preserved after the discharge of the patient.
12.6 LET US SUM UP

In this practical we have discussed maintenance of records. You learnt how these records are important for patient/client care. By now you have understood the purposes of records, types of records and information required for record keeping. You should also have a fair idea of how these records are maintained and general and specific guidelines to be followed while recording. You need to do the exercise of recording. Most of the questions you will be required to attempt would be to compare records of patients/clients of various paediatric age group.