UNIT 3 LEGAL IMPLICATIONS IN RECORDS AND REPORTS

Sturucture

3.0 OBJECTIVES

After going through this unit you should be able to:.

- explain definition and meaning of the records and reports;
- list the purpose of records;
- describe the Importance of records;
- apply the principles and essentials of records;
- identify the issues and problems of records;
- illustrate the records and reports maintained by nurses in various areas like nursing education, nursing service administration and community health nursing; and
- list the types of reports used in health agencies.

3.1 INTRODUCTION

Medical records serve to identify each patient and evaluate both patient and hospital progress. It forms a legal document of a specific case, and even may aid in the treatment of some other specific case as well. Records reveal professional standard of an institution and persons employed for caring for the patient.

Every organization keeps some kind of records. Every department in the hospital has its own records. Same way community health department also keep various record. Nursing

and reports maintained by nurses in the hospital, community health department and nursing school's and colleges. Emphasis given on nurse's responsibilities for keeping the records and reports.

3.2 OVERVIEW: DEFINITIONS AND MEANING OF RECORD AND REPORTS

A good communication in any given institution largely speaks through its records and various reports maintained. While working in the field of nursing, as an administrator, practitioner, educator or researcher a nurse need to maintain various records as per the area of work.

3.2.1 Definition of Record

"Record is piece of information or evidence constitutive account of something that has occurred preserved in writing." — Oxford

"Records are the means of communicating essential facts in writing in order to maintain a continuous history of events over a period of time." — Dugas

3.2.2 Meaning of Record

The dictionary meaning of record is a written report of any fact or facts, or to put a matter down in writing so that it may be read or referred after wards where as Reporting is giving account of something, telling about something.

Nursing record is a clinical, scientific, administrative and legal document relating to patient care in which is written sequence of events to justify the nursing diagnosis, the treatment and end results.

3.2.3 Definition of Reports

"To bring back, give an account of anything especially a format or official account." — Oxford

"Reports are the effective methods of communication among the member of the team or group." — Dugas

Reports are oral or written exchanges of information shared between care givers or workers in a number of ways. A report summarizes the services of the person or personnel and of the agency. Reports are usually written daily, weekly, monthly or yearly.

Check Your Progress 1

1) Write the meaning of nursing record.

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2) Define report.

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3.3 PURPOSES AND IMPORTANCE OF RECORDS

In this subunit we will acquaint you about purposes and importance of records. In your practice you are recording all the procedures but in this subunit we are going to tell you purposes and records and importance of records.

3.3.1 Purposes of Records

- To have a record of patient particulars for reference at all times,
- It helps the staff to understand the comprehensive needs of the patients and their problems.
- It helps to coordinate the work of nursing staff with other personnel.
- It helps in the guidance of staff and students when planned records are utilized as an evaluation tool during conferences.
- It helps the administrator to assess the health assets and need of the community.
- It helps in making studies for research.
- It helps in planning budget and provides statistical data.
- It provides justification of expenditure of funds.
- It serves as legal documents and protects the organization in the event of legal questions.
- It serves as a legal evidence of the services rendered by each employee or worker.
- In a training institution, the records are used as reference for teaching.
- It helps to avoid errors or overlaping of work.

3.3.2 Importance of Records

- Helps in sound decision making.
- Helps in effective communication and internal control.
- Facilitates in evaluation of corporate performance.
- Promotes efficiency of operations.
- Fulfills statutory requirement.
- Helps in ascertaining future trends.
- Indicates statistics.

Check Your Progress 2

Write the importance of records.

3.4 ESSENTIALS OF RECORDING

Management decisions are based or accurate, complete and timely information these are likely to lead to better performance of the organization. Recording of the information is major function of the office. Nursing staff should keep in mind certain principles of recording while she/he records nursing care.

3.4.1 Principles of Recording

1) Each record should be for a specific purpose, which should be clearly understood by those maintaining and using the records.

2) The records should contain only such information regarding any patient or person as is really necessary far conducting evalution of nursing services. All irrelevant material should carefully be avoided.

3) All wording should be simple and understandable, should any doubt arise, instructions to facilitate interpretations should be included.

4) All appropriate records should permit freedom of expression.

5) Necessary records required by the teaching staff should be easily accesibre to them.

6) All persons responsible for maintaining records should be aware of their particular responsibility. And thus every effort must be made to keep these records up to date.

7) A very simple method should be used for routine recording. And the system should be a standardized one for speed accuracy and reliability.

8) There should be a provision for periodic review of all records to ensure that they keep pace with the changing needs.

9) There should be quite an adequate supply of stationary to permit maintenance of the records on proper forms etc. at all times.

10) There should be sufficient filing space which should be safe and fire proof.

11) Filing system should be simple and safe, requiring minimum time and expenditure.

12) Items on forms and in registers should be grouped conveniently so as to make their completion as easy as possible.

3.4.2 Essentials of Good Document

A document should have the following characteristics.

- Have specific objective and purpose.
- Have classification system.
- Kept to the minimum in number and content.
- Cost effective.
- Easily retrievable.
- Complete, factual, authentic, accurate, comprehensive, concise and brief
- Legible, written in black ink preferably typed for better legibility, and in chronological order as to date and time.
- Signed by the individual who writes them.
- Subjected to periodic review.
- Use only standard abbreviations.

3.4.3 Issues and Problems of Records

- There is no uniform standard for maintaining records any where.
- Shortage of experienced personnel.
- Need of effective handling and processing of records.
- Use of expiry dated forms.
- Lack of place to store the records.
- Evaluation of record handling.
- Need to specify the records retention period.

In this section we have discussed the principles of recording, essentials of good documents and certain issues and problems faced by the nursing personnel in keeping the records.

Check Your Progress 3

List the issues and problems of records.

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3.5 RECORDS AND REPORTS IN NURSING EDUCATION

In this sub section you will learn various types of records and reports in Nursing Education.

Records

Records play an important part in a nursing education programme. A part from being necessary for the day to day administration of the school of nursing/college they provide continuity of maintaining them will vary from one educational instution to another but there are a few principles which are basic to all.

Let us examine the principles of maintating schoollcollege records.

1) Each of the records should be for a specific purpose which should be clearly understood by those maintaing and using the records.
2) The records should contain only such information regarding the students, staff and other aspects of the programme as is really necessary for conducting the school and for evaluation. Irrelevant material should be carefully avoided and records should not be duplicated.
3) Items on forms and in registers should be conveniently grouped so as to make their completion as easy as possible.
4) The wording should be easily understood.
5) Records should permit some freedom of expression.
6) Required records should be easily available for the teaching staff.
7) Persons responsible for maintaining records should be aware of their paricular responsibilities and every effort should be made to keep records up to date.
8) A simple system should be used for keeping records. The system should be standardized as much as possible for speed, accuracy and reliability.'
9) There should be provision for periodic review of all records to ensure that they keep pace with the changing needs of the programme.
10) There should be an adequate supply of stationery to permit records to be maintained on the proper forms and in the proper registers at all times,
11) There should be adequate, safe, fire proof storage arrangements.
12) There should be a sufficient number of filing cabinet and appropriate equipment to operate a filling system which is simple and safe and requires the minimum expenditure of time.

We have discussed that certain principles should be kept in mind while maintaining records in the school and college.

Now let us see the various records kept in a nursing schoolfcolleges.

Types of school records.

a) School/Students Records

The number, variety and content of records kept in regards to students will vary from one school to another. This is particularly true in relation to the records of the student's performance. The following list is intended as a guide to minimum which should be maintained in the school office.

- Application forms and other reports, recruitment, selection and appointment of students.
- Record of each student's for the theory/practical experience in each subject.
- Progress report for each student in examination marks, internal assessment awards etc.
- Health records for each student.
- Cummulative Record.

  The cummulative record is a systematic accumulation of significant factual information about an individual which when progressively developed and maintained over a sufficient period of time, gives a summarized "growth record" indicating the direction and rate of development. It shifts the emphasis from a one time or once a

year performance in a few academic subjects to the full development in practically all the important aspects of education and general, physical, social and mental development over a longer period of time.

b) ***Faculty/Staff Records***

- Personal file for each faculty and staff includes: copy of the letter of appointment, application forms and other relevant letter as per the policy.
- Job description — job specification, work load.
- Record of faculty members/staff members educational qualifications, previous experience, any short term courses attended, membership in professional actiyities, publication, holding office in association or organization participation in conferences and seminars.
- Periodic evaluation or progress report.
- Leave record and/or health record.
- Service book.
- Performance apprisal.

c) ***General School/College Records***

- Philosophy, aims, and objectives of the institution.
- Curriculum of the school/college.
- Prospectus for college/school.
- Written policy of the school in various areas i.e. Library, A.V aids (all types), Discipline, Hostel policy etc.
- Budget proposal and allotment to various department.
- Inward and outward register.
- Inventories of stock.
- Records and Reports of various committees.
- Admission records of students.
- Report. of state council.
- Reports of Indian nursing council.
- Affiliation and continuation letters and records of the university.
- University reports for the inspection.
- Rules and regulation for the university examination.
- Records for the extra curriculum activities.
- Records of important landmark of the school/college.
- Governing body meetings proceeding while governing body exists.

Reports of School/College of Nursing

The number and nature of reports will depand on what is required by the controlling body, nursing councils and the university reports are detailed worked out facts about school/ college.

The type of information which is commonly required in an annual report is as follows.,

a) Factual data relating to students, staff and the faculty.

b) Factual data relating to physical facilities, clinical facilities, administration and the curriculum.

c) Any change in the school/college programme than of the previous report.

d) Proposals and plans for future development.

e) Problems encountered.

f) Recommendations (if suggested).

We have discussed the records to be kept in the educational institution, principles should be followed while keeping the records in the school/college. Annual reports are useful for

Check Your Progress 4

1) List the types of records maintained in the school of nursing.

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2) Write information included in the annual report of nursing school.

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3.6 RECORDS IN NURSING SERVICE ADMINISTRATION

You might have observed and maintained the records and reports during your experience. The keeping of records is a necessary activity in every administrative and educational organization. Now you will learn about Nirsing Administrative records.

a) **Nursing Administrative Records**

These are concerned with hospital and also includes personnel service records of each individual in service. It may vary according to type of organization. It has educational value too.

These records can be maintained all the unit level and submitted to the nursing superintendent/Matron. The records can be:

- Number of nurses on roll in the unit/ward/department and rotation plan.
- Weakly duty schedule/monthly duty schedule of nursing staff.
- Record of staff development programme including orientation, in service education programme.
- Records of performance of nursing staff members.
- Dead stock register of the unit for medicine, linen, equipment and supplies.
- Annual confidential reports of the staff nurse.
- Performance appraisal, self evaluation, peer group evalution records and anecdotal records.

Nursing superintendent has to keep certain records readily available:

- Hospital hand book.
- Hospital brochure.
- Hospital annual report.
- Philosophy, aims and objectives of the hospital.
- Policies of the hospital for recruitment/selection/promotion and other area.
- Total number of nurses on the roll.
- Hospital map and physical layout of the various departments.
- Confidential records of the nursing personnel.
- Staff development records.
- Record of the meritorious work performed by the nursing personnel.
- Any disciplinary action record.
- Records of various committees and meeting memorandum notices etc.
- Students rotation plan.
- Visitors book.

b) Clinical Records

The value of clinical records is both scientific and legal. It serves as evidence to the patient that his care is being intelligently managed. Nurse should study the record forms system and make recommendations for changes that will help in meeting the needs of the organization and community in the most effective manner. These records are maintained in the wards as well as in the departments.

- ***Admission Record***

This record is important from both the legal and the diagnostic point of view. The nurse admitting the patient includes a full description of his/her symptoms both related and unrelated to the condition for which he/she was admitted. Observe the patient's condition like condition of skin such as burns, wounds, bruises, rashes, swelling, cuts; condition of mouth and teeth, presence of sordes, ulcers, or other lesions, visible caries, dentures, bleeding, swelling, enlargement of mass. Any condition which may influence the nursing care of the patient should be included in the nurses notes.

- ***Nurses Notes***

The importance of nurse's notes, the need for accurate, intelligentand legible notes and the significance of such notes in determining legal liability cannot be overemphasized with the discharge of patient their charts automatically do not lose their importance.

Nursing notes should describe accurately not only any typical enatic changes in the patient's condition, but also any in subordination, lack of co-operation or other behavioural problems, such observations might later provide some answers to questions relating to why and where of some incident, patient's complain should always be recorded as accurately and specifically as time and space of the chart permits.

- ***Charts***

The patient's chart is the physical property of the hospital. Patient's chart is not an object for general exhibition and inspection. The chart has to go out of the institution the competent authority must give a written statement to this effect the chart usually used in the hospital are vital signs/symptoms chart, in-take out-put chart, nursing care plan and progress report of the patient.

The main responsibility of the nurse is to give comprehensive nursing care to the client and records the procedures in the chart. While charting, the following points are very essentials.

Essentials of Good Charting

a) Accuracy avoid errors in spellings, abbreviations and grammar, names of patient and doctor must be complete and correctly spelt on each sheet of the bedside record. Accuracy in recording of details up to the very minimum, and up to the very second is most essential.

b) Promptness in recording of every important observation and development is a special feature.

c) Careful itemization of all services performed in carrying out of physician's orders.

d) Legibility and neatness with no erasures and eradications.

e) Conciseness in rendering services should indicate use of good judgement and common sense.

f) Arrangement of the chart must be chronological. It should be up to date. Record as the happenings take place.

g) Knvolvement of minimum expenditure of time in recording.

h) Designing of records to ensure uniformity, specificity and objectivity.

i) The record must contain answers to all necessary questions. K is impossible10 go back later to find the answer to many questions that have been omitted.

j) Safety of patient's record is entrusted to the nursing staff during the patient's hospitalization. The record is, therefore, released only to professional staff members,

- *General Records*

The records of equipment losses and replacements are kept in the central accounting office. The responsibility of the head nurse is to evaluate work of her staff. Evaluation of their work and discussion with each individual are necessary for growth. Head nurse job is to write performance evaluation and send to the nursing superintendent regularly.

Other records as per the requirement of the unit/ward/department. And as per policy of the organization.

Check Your Progress 5

What are the essentials of good charting?

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3.7 RECORDS AND REPORTS IN COMMUNITY HEALTH NURSING

You have already studied recording and reporting in the hospital and nursing school too, now Jet us discuss record and reports related to community health nursing in brief.

The service of a community health nurse will be meaningful only when it is properly recorded and maintained. Community health nurse has the responsibility to record informations as accurately as possible and submit them timely as per prescribed guidelines.

Health records refer to forms on which information about an individual and his family is noted. The family records serve as a guide to the nursing care, as today they are major practice tools in the community health practices. Records and reports help to assume and improve the quality of the care given and is a tool useful for supervision.

- **Purposes of Records**

1) To provide the staff member, administrator, or responsible governing body of the institution with documentation of the services that have been rendered.
2) To provide data for programme planning and evaluation.
3) To provide the community health nurse with data required for family health.
4) Tools of communication between the health worker the family and other development personnel.
5) Record indicates plan for the future.
6) It provides baseline data to estimate the long term changes related to the services.
7) It provides an apportunity for evaluating the services.
8) It helps in the research for improvement in community health nursing care.

Family health record represent a comprehensive, systematically organized, and perceptive set of data that puts into quickly accessible and assimilated forms the information essential for disaster management and in dicission making.

- **Types of Family Health Records**

Family health records is comprised of a mixture of prescribed or standard forms identical to those of other agencies, and of forms designed to meet the needs of the particular agency. The state government of health department supply prescribed record forms.

Different family health records which are commonly used are as follows:

1) According to the age of family member
   - New born care.

- a Preschool card/ toddler card.
- a Road to health.
- Adult card.
- Old age or elderly card.
- Mother child link card.

2) According to the health services provided in the family

Antenatal care card.

- Labour record card.
- a postnatal care card.
- Person with illness: for example
  - Tuberculosis record.
  - Diabetic record.
  - Hypertension care card,
  - Leprosy care card.
  - Goitre care card.
  - Malaria card.

Drug addicts or alcoholics record.

- Any other chronic diseases care record.
- Immunization record.

These records are in the form of:

- Folders.
- File.

Cards.

- Charts.
- Register (printed book).

As we have discussed types of records maintained in community health services by the health personnel, which includes socio demographic information, children health record, maternal records, elderly person's record, disabled person's record and other needs of the family.

- **Criteria for Recording In Family Health Records**

The criteria for recording should reflect the purpose and the process of community health nursing practice.

Criteria

1) Record focus on the family and community as the object of care.
2) Record present the problem in comprehensive, explicit and dynamic terms.
3) Record indicate the outcomes considered feasibility.
4) Record should clearly show the specific planned of action carried out.
5) Record should identify the family response to the problem and to sub sequent nursing action.
6) Record should provide for quick reference to periodic comprehensive assessment.
7) Record should be preserve according to the policy of the institution or organization.
8) Record system should provide confidentialily of record.

Check Your Progress 6

List purposes of family health records.

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3.8 TYPES OF REPORTS

Reports are oral or written exchange of information shared between care gives or workers in a number of ways. **A** report summarizes the services of the person or personnel and of the agency, Reports are usually written daily, weekly, monthly or yearly.

A good reports serves the following purposes:

1) Purposes

- To show the kind and amount of services rendered over a specified period.
- To illustrate progress in reaching goals.
- As an aid in studying health conditions
- As an aid in planning.
- To interpret the services to community and to the agencies.

2) Types

On the basis of day to day function reports can be classified as:

- Day, evening, night reports,
- Interdepartmental reports.
- Special reports on unusual condition in the patient.
- Reports on mistakes, accident, and incident.
- Reports on complaints.
- a Transfer reports.'
- Legal reports.

On the basis of time period report can be:

- Daily.
- Weekly.
- Monthly.
- Yearly.
- Periodical.
- Annually.

The reports used in hospital setting usually are change of shift reports, transfer reports, incident reports day, evening and night reports, legal reports.

a) **Change of Shift Reports**

These may be given orally in person by audiotaping, recording or during rounds at the clients bedside some of the points to be kept in mind while giving reports.

- a Give only essential information about client.
- Identify clients needs/problems and other related causes.
- Describe objective observations about clients condition and responses but do not use critical comment about clients behaviour.
- Continuously review on-going discharge plan.
- Describe instruction given in teaching plan and client's responses.
- Evaluate results of nursing care or medical care.
- Be clear on priorities to which on coming staff must attend.

b) **Transfer Reports**

A transfer report involves communications of information about clients from the nurse on sending unit to the nurse on the receiving unit, nurse should includethe following

- Client's name, age, sex, doctor's unit and medical diagnosis.
- Summary of health status--physical and psycho-sociel.
- Current nursing diagnosis or problems and care plan.
- Any critical assessment or interventions to be completed shortly.
- Needs for any special equipment etc.

c) Incident Reports

Nurse must understand the purpose of incident reports and the correct way to report information. While incident reporting, the foilowing points are to be kept in mind,

- The nurse who witnessed the incident should file the report.
- The nurse describes in concise what happened specifically objective terms etc.
- The nurse dose not interpret or attempt to explain the cause of the incident,
- Any measures taken by nurse/doctors are reported.
- No nurse is blamed in an incident report.
- Report should be submitted promptly to the appropriate authority.
- The nurse should never make photocopy of the incident report.

d) Legal Reports

Incident reports and reports on accident mistakes and complaints are negligence or poor care because of a condition that resulted in discomfort and perhaps serious harm to a patient or client. In such reports the content is started briefly and objectively giving all pertinent information. Accuracy, timeliness, completeness and relevancy to the problems are maintained promptly while making such reports.

To whom

While working in the hospital/wards/departments a nurse needs to give reports to various personnel.

- Head nurse and her assistant.
- Head nurse and nurse's who are assigned to bed side care.
- Staff members to the charge nurse.
- Charge nurse's to the bed aide nurse.
- Head nurse to the administrative supervisor.
- Report to the clinical instructor.
- Head nurse to director of nursing (Nsg. superintendent) or her assistant.
- Charge nurse to the physician.

3.9 NURSE'S RESPONSIBILITY IN KEEPING RECORDS AND REPORTS

Nurse have legal responsibility for accurately reporting and recording patients conditions, treatment and responses to care. A complete record is the best safeguard that a nurse can have. Always remember that records may have to be produced in the court and con be a sound proof for a nurse's work load, where assistance and help were essential, indicating her inability of providing reasonable care to the patient.

It is nurse's responsibility to safe guard the patient's record, hence need the document8 should.

1) Be kept under safe custody, protect from loss/destruction.
2) Not be separated into individual sheet.
3) Not be accessible to patients as well as strangers.
4) Kept confidential.
5) No: to be given over to legal advisors without written permission of authority.
6) Be handled carefully.
7) Be filed according to the hospital norms, systematically so that they can be

8) Never be sent out of the hospital without the authorities permission in writing.

The head nurse likewise is responsible that the content of the nurse's notes be such that they are of legal, scientific and educational value.

Check Your Progress 7

1) Enumerate the purposes of good reports.

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2) List the reports used in hospital setting.

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3.10 LETUSSUMUP

The keeping of records and reports is a important activity in every administrative and educational organization. It serve the purpose of providing complete information about the direct care delivered by the agencies indicating the extent and quality of services being rendered resolving legal issues in malpractice suits and providing information for education and research. Reports are oral and written when they may be needed for legal purposes when they are to serve as source of reference. Reports can be classified on basis of day to day function and on the basis of time penod. Reporting should be done to the responsible person on duty and who is concerned responsibility of nurse to give report prompt, complete, accurate and objective.

3.11 KEY WORDS

Criteria	:	Principle by which something is measured for value.
Form	:	A form is a standardized record used to acence purposes.
Medical Record	:	To refer to the case notes of each patient treated at the hospital.
Prescribed Records	:	Records which are used in the agency on the advice of the authority.
Uniformity	:	Condition of being the same throughout.

3.12 ANSWERS TO CHECK YOUR PROGRESS

Check Your Progress 1

1) Nursing record is a clinical, scientific, administrative and legal document relating to patient care in which is written sequence of events to justify the nursing diagnosis, the treatment **and** end results.

2) Reports are oral or written exchange of information shared between care givers or workers in a number of ways. A report summarizes the services of the person or

Check Your Progress 2

It helps in sound decision making.

- It helps in effective communication and internal control.
- It facilitates in evaluation of corporate performance.
- It promotes efficiency of operations.
- It fulfills statutory requirement.
- It helps in ascertaining future trends,
- It indicates statistics.

Check Your Progress 3

- No uniform standard for maintaining records.
- Shortage of experienced personnel.
- Need of effective handling and processing of records.
- Use of expiry dated forms.
- Lack of place to store the records.
- Need to specify the records retention period.

Check Your Progress 4

1) a) School/student record.
   b) Faculty/staff record,
   c) General record.
2) a) Factual data relating to students, staff and the faculty.
   b) Factual data relating to physical, clinical and educational.
   c) Proposals and plans for future development.
   d) Problems encountered.
   e) Recommendation,

Check Your Progress 5

- Accuracy
- Promptness
- Carefulness
- Legibility and neatness
- Conciseness
- Systematic
- Uniformity
- Safety

Check Your Progress 6

- Provide documentation of the services to the concerned.
- Provide data for family health.
- Tools of communication.
- Indicates plan for the future.
- Helps in planning for the long term.
- Helps in evaluating services.
- Helps in research work.

Check Your Progrers 7

- To show the kind and amount of services rendered over a specified period.
- To illustrate progress in reaching goals.
- As an aid in studying health condition.
- As an aid in planning.
- To interpret the services to community and to the agencies.
- Change of shift reports,
- Transfer reports,
- Incident reports.
- Legal reports,