UNIT 6  RECORDS AND REPORTS

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6.0  INTRODUCTION

In the previous unit you have learnt financial management and accounts. In continuation this unit deals with records and reports. As you know that records are a source from which data can be collected, it becomes basis for assessment of needs and future planning. You will also learn about various reports to be submitted at the place of work, information provided in monthly reports. Records evaluate previous performance with current status.
6.1 OBJECTIVES

After completing this unit, you should be able to:

- list the records to be maintained at sub-centre/ FRU level;
- explain the importance of records to be maintained and reports to be prepared at sub-centre /FRU level;
- identify the official records to be maintained and reports to be submitted under the provision of community health nursing practice;
- discuss the guidelines to be used for maintaining the up to date records. And sending the reports to appropriate authority;
- explain about the surveillance and role of Nurse health practitioner in the surveillance;
- describe the information to be provided in monthly reports and prepare the reports in the prescribed formats under the current health programme; and
- evaluate your own performance by assessing the reports prepared by you.

6.2 CONCEPTS OF RECORDS AND REPORTS

A record is a permanent written communication that documents information relevant to a client’s health care management, e.g. a client chart is a continuing account of client’s health care status and need. –Potter and Perry

An effective health record shows the extent of the health problems’ needs and other factors that affect individuals their ability to provide care and what the family believes. What has been done and what to be done now also can be shown in the records. It also indicates the plans for future visits in order to help the family member to meet the needs.

All documents information, regardless its characteristics, media, physical form and the manner it is recorded or stored. Records function as evidence of activities. Express or presenting facts, data, figures or other information in writing is called records means written information. Health records refers to the forms on which information about an individual or family is recorded.

The performance or output of services rendered by the staff are reported on the formats prescribed. This information is communicated from the lowest to highest level of health services, They are also used as important management tools for assessment of quality and quantity of services provided, which further helps in decision making process for future action plans. These reports also help to understand if planned services are provided or not.

6.2.1 Importance of Records and Reports

- Assess health level of the community
- Helps in collecting data
- Assessment and evaluation of work
- Basis for formulating plans
- Tool or medium for health education.
• Determine needs of resources
• Legal documentation
• Means of communication
• Provide information of good nursing
• Conduct training and research work
• Assess health problems

6.2.2 Legal Implication of Records and Reports

There are three approaches to legal implications of records and reports:

1) **Individual approach:** Records of importance are birth records, death records etc. They are valuable documents not only from health department also from other departments.

2) **Community approach:** Health records provide conformation and protection of rights related to health. It presents charges through which charges can be taken against medical administration and political system. It could lead to proper implementation of services.

3) **Nursing approach:** It is important preserving individual records of health. Confidentiality and privacy has to be maintained. These documents should be shown to authorised person. The value of the record when they are presented at the right time. Legally accepted process should be followed for destroying obsolete records. Records of medico legal cases should be handled carefully.

6.2.3 Purposes of Records

1) Supply data that are essential for programme planning and evaluation.
2) To provide the practitioner with data required for the application of professional services for the improvement of family’s health.
3) Records are tools of communication between health workers, the family, and other development personnel.
4) Effective health records shows the health problem in the family and other factors that affect health.
5) A record indicates plans for future.
6) It provides baseline data to estimate the long-term changes related to services.
7) Legal documents: poisoning, assault, rape, LAMA, burn etc.
8) Research or statistics: rates
9) Audit and nursing audit
10) Quality of care
11) Continuity of care
12) Informative purposes: census
13) Teaching purpose of students
14) Diagnostic purposes: test reports
6.2.4 Value and Uses of Records

Let us go through the value of records for the nurses, doctors, and for the Community and Organisation as discussed below:

For the Nurse:
- Provides basic facts for service.
- Provides a basis of analysing needs.
- Provides a basis for short term and long term planning.
- Prevents duplication of service.
- Helps evaluate care and teaching given.
- Helps follow-up services effectively.
- Helps to organise work.
- Serves as a guide to professional growth.
- Enables to judge the quality and quantity of the work done.

For the Family and Individual:
- Creates awareness.
- Helps to recognise health needs.
- Can be used as teaching tool.

For the Doctor:
- Serves as a guide for diagnosis, treatment and evaluation of services.
- Indicates progress.
- May be used in research.

For the Sanitarian:
- Identify families needing service.
- Draw nurses attention to any pertinent observation made.

For the Community and Organisation:
- Evaluate services rendered, teaching done and persons action and reactions.
- Helps in the guidance of students.
- Helps administrator to assess the health needs and needs of village/area.
- Helps in making studies for research, for legislative action and for planning budget.
- Is a legal evidence of service rendered.
- Provides justification for expenditure of funds.

6.2.5 Principles of Record Writing

1) Nurses should develop their own method of expression and form in record writing.

2) Records should be written clearly, legibly and appropriately.

3) Records should contain facts based on observation, conversation and action.
4) Select relevant facts and the recording should be neat, complete and uniform
5) Records should be written immediately after an interview.
6) Records are confidential documents.
7) Records are valuable legal documents and so it should be handled carefully, and accounted for.
8) Records systems are essential for efficiency and uniformity of services.
9) Records should provide for periodic summary to determine progress and to make future plans.

6.2.6 Filling of Records

Different systems may be adopted depending on the purposes of the records and on the merits of a system. The records could be arranged:

- Alphabetically
- Numerically
- Geographically and
- With index cards

Records should be Permanent, Secure, Traceable

- Permanent,
- Secure: Maintain confidentiality
  Limit access
  Protect from environmental hazards
- Traceable: Sign and date every
  Keep books bound record
  Number pages
  Use permanent ink
  Control storage

6.3 TYPES OF RECORDS

There are different ways to know the type of records. Let us discuss each one by one:

1) **Cumulative or continuing records**
   - This is found to be time saving, economical and also it is helpful to review the total history of an individual and evaluate the progress of a long period. (e.g.) child’s record should provide space for newborn, infant and preschool data.
   - The system of using one record for home and clinic services in which home visits are recorded in blue and clinic visit in red ink helps coordinate the services and saves the time.

2) **Family records**
   - The basic unit of service is the family. All records, which relate to members of family, should be placed in a single family folder. This gives
the picture of the total services and helps to give effective, economic service to the family as a whole.

- Separate record forms may be needed for different types of service such as TB, maternity etc. all such individual records which relate to members of one family should be placed in a single family folder.

Some scholars have classified records under four headings. They are as follows:

1) **Periodical:**
   a) Permanent records (cumulative)
   b) Temporary records (casual/daily records)

2) **Unit Based Records:**
   a) Individual (individual health cards)
   b) Related to family (family folders)
   c) Related to community (community folders)
   d) National (national health programs records)

3) **Subject Based:**
   a) Economical (financial structure of family, village)
   b) Social (records of social structure)
   c) Political
   d) Medical and nursing (treatment and medicine records)

4) **Collection Place Based:**
   a) Collected at institutions (records of hospitals/ health Centres)
   b) Records to be kept with the individual (immunisation cards, disease cards)

**6.3.1 Records Related to Community**

These are of two categories:

a) Records to be kept under health centres
b) Records to be kept with the patient

a) **Records to be kept under health centres**

Family folders: MCH cards
   Antenatal card/ postnatal cards
   Infant card
   Pre-school child card
   Medicine distribution card include records of iron and folic acid distribution cards

Family welfare records: Eligible couple,
   MTP,
   Family planning.
   Treatment and referral records

Vital event records: birth and death records
General information records: Individual records
   Family
   Village
   Map of community

Other records: antenatal records
   Medicine records
   Monthly/ yearly records
   Consumable stock register
   Stationary stock register
   Daily diary
   Cumulative records

b) **Records to be kept with the Patient (Kept under supervision of community health nurse)**

These are:
- Health record of school going children
- Infant health card
- Maternal card
- TB patient card
- Individual health card
- Birth and death record
- Inpatient and outpatient record
- Eligible couple records

**6.3.2 Registers**

It provides indication of the total volume of service and type of cases seen. Clerical assistance may be needed for this. Registers needed to be maintained at FRU are:
- MCH Register and Immunisation card- Maternal care, Birth, Newborn and child care.
- Registers for recording Contraceptives:
  - Condom distribution register
  - Oral pill register
  - CU ‘T’/IUD register
  - Sterilization register – Male and female
- FRU clinic register/OPD register
- Admission and Discharge register
- Death register
  * Stock register
  * Referral register
  * Duplicate copy of the monthly report submitted for each month.
6.3.3 General Guidelines for Maintaining Records

1) Enter information in the proper place.
2) Write down information immediately as soon as possible. Delay results in incomplete and inaccurate records.
3) Maintain records up-to-date daily and avoid letting records being piled up.
4) Write clearly and neatly. It should be legible.
5) Keep records in order either alphabetically/numerically/geographically and with index card.
6) Keep all the registers in cupboard, dust regularly and protect from rats, cockroaches and termites.
7) Treat records confidential and do not allow unauthorised person to read the records.
8) Maintain an adequate stock of stationary, registers and all forms needed to be filled and submitted.
9) Destroy all old records (i.e. more than 5 years old).

Maintenance of Health Record at Facility Level

a) Village Register
The register is maintained to store the information regarding an overall picture of each village covered under the sub-centre area.

b) Household Survey Register
The information regarding each and every household is collected during household survey. After the initial survey, it should be revised after three years. The details of information need to be collected and entered in the survey register.

c) Eligible Couple Register
Identify the number of couples where the wife’s age is between 15–45 years from household survey register and enter in this register with address. The family status with parity and age of the youngest child should also be mentioned. The couples if using any contraceptives also need to be recorded along with the details of contraceptives methods being used.

d) Maternal and Child Health Register cum Contraception Register
Is just like the family folder with maternal data (antenatal, natal and postnatal) record and under five records of the child, adolescent card and eligible couples use of contraceptives methods.

e) Sub-centre/FRU Clinic Register
This register is maintained for keeping records of patients attending the sub-centre clinics. The attendance in antenatal, immunisation, family planning clinics should not be registered in this record.

f) Death Register
All deaths occurring in the area are covered by the sub-centre are entered in this register.
Records and Reports

Records of particulars related to all items provided and utilised at sub-centre should be maintained.

Register for Recording Consultative Process

As an important member of the health team you have to conduct meetings with village working team constituted for each village and with other members of the group of that village. The details of the meetings are recorded of each meeting in the register.

Referral Register

The details of the referred cases should be entered in the register. This will also help to undertake follow-up of the referrals made.

Daily Diary

The daily diary is maintained by the Health Team Members in which the daily activities are performed in the field as well as the clinic with regard to immunisation, antenatal checkup and follow-up, distribution of contraceptives, follow-up of IUD and OP cases, identification of PID, RTI/STI cases, birth and death reported, malaria cases etc. The meetings conducted with the village working team and the group of village representatives should also be mentioned in the diary.

The daily diary will enable to update all the register to be maintained and will also be helpful in preparation of the monthly report. It is easy to carry one daily diary instead of all the registers when one goes on home visits/meetings.

Check Your Progress 1

1) List the purposes of record keeping.
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2) List the types of records to be kept at the health centre.
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3) Explain the legal implication of records.
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4) List the principles of record writing.
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5) List the patient records to be kept at health centre and with the patient.
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   ................................................................................................................
6) List the registers to be maintained at the health centre.

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7) Describe the guidelines for maintaining records.

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6.4 REPORT WRITING AND DOCUMENTATION OF ACTIVITIES CARRIED OUT DURING FIELD/HOME VISITS

Let us now learn about reports, purpose of writing reports in details:

Reports

Potter and Perry stated that “a report is a summary of activities or observations seen, performed or heard”. These are account or statement describing in detail an event, situation, or like, usually as the result of observation, inquiry, etc. a formal or official presentation of facts. Some important aspects to be considered are:

- Reports can be compiled daily, weekly, monthly, quarterly and annually.
- Report summarises the services of the nurse and/or the agency.
- Reports may be in the form of an analysis of some aspect of a service.
- These are based on records and registers and so it is relevant for the nurses to maintain the records regarding their daily case load, service load and activities.
- Thus the data can be obtained continuously and for a long period.

6.4.1 Purposes of Writing Reports

- To show the kind and quantity of service rendered over to a specific period.
- To show the progress in reaching goals.
- As an aid in studying health conditions.
- As an aid in planning.
- To interpret the services to the public and to other interested agencies.

6.4.2 Type of Reports

1) Performance in corresponding month of last year
2) Performance in the reporting month
3) Cumulative performance till corresponding month of last year
4) Cumulative performance till current month
5) Planed performance in current year
6.4.3 Criteria of Good Report

- Can be made promptly
- Clear, concise and complete
- All pertinent, identifying data included
- Mention all people concerned, situation and signature of person making report
- Easily understood
- Important points are emphasised

Key Messages

- Written policies and procedures are the backbone of the quality system
- Complete quality assurance records make quality management possible
- Keeping records facilitates meeting programme reporting requirement
- Records and reports reveals the essential aspects of service in such logical order so that the new staff may be able to maintain continuity of service to individuals, families and communities.

6.5 MEDICAL RECORD DEPARTMENT

Medical Record of the patient stores the knowledge concerning the patient and his care. It contains sufficient data written in sequence of occurrence of events to justify the diagnosis, treatment and outcome. In the modern age, Medical Record has its utility and usefulness and is a very broad based indicator of patients care.

6.5.1 Filing of Medical Records

- The inpatients Medical Record is filed by the serial numbers assigned at central Admitting Office.
- The Record is bound in bundles 100 each and are kept year wise according to the serial number.

6.5.2 Retention of Medical Record

- The policy is to keep indoor patient Records for 10 years
- The OPD registers for 5 years
- The record which is register for legal purposes in Maintained for 10 years or till final decision at the court of Law

6.5.3 Functions of Medical Record Department

1) Daily receipt of case sheets pertaining to discharge and expired patients from various wards, there checking and assembly.
2) Daily compilation of Hospital census report.
3) Maintains and retrieval of records for patient care and research study.
4) Completion and Procession of Hospital statistics and preparation on different periodical reports on morbidity and mortality.
5) Online registration of vital events of Birth and Death.
6) Issuing Birth and Death certificated up to one year.
7) Dealing with Medico Legal records and attending the courts on summary.
8) Arrangement and Supervision of enquiry and admission office.

6.6 ELECTRONIC MEDICAL RECORDS (EMR)

Let us now learn electronic medical records.

The IOM 2003 Patient Safety Report describes an EMR as encompassing:

- “a longitudinal collection of electronic health information for and about persons
- Immediate electronic access to person and population-level information by authorized users;
- Provision of knowledge and decision-support systems that enhance the quality, safety, and efficiency of patient care and
- Support for efficient processes for health care delivery.”

The 1997 IOM report “The Computer-Based Patient Record: An Essential Technology for Health Care” defines an EMR as: “A patient record system is a type of clinical information system, which is dedicated to collecting, storing, manipulating, and making available clinical information important to the delivery of patient care. The central focus of such systems is clinical data and not financial or billing information.”

6.6.1 Capabilities and Components of an Electronic Media Record (EMR)

There are three essential capabilities of an EMR. They are:
1) To capture data at the point of care,
2) To integrate data from multiple internal and external sources, and
3) To support caregiver decision making.

Components of an EMR

- Results reporting
- Data repository
- Decision support
- Clinical messaging and e-mail
- Documentation
- Order entry

6.6.2 Electronic Health Record (EHR)

It is a longitudinal electronic record of patient health information generated by one or more encounters in any care delivery setting. There are interoperability standards to exchange information outside a single healthcare delivery system. It supports other care-related activities directly or indirectly— evidence-based decision support, quality management, and outcomes reporting.
6.6.3 Levels of Automation

- Stage 0: Not all ancillary systems (Lab, X-ray, Pharmacy) are operational
- Stage 1: Major ancillary clinical systems installed
- Stage 2: A clinical data repository (CDR) stores information from major ancillary clinical systems
- Stage 3: Basic clinical documentation required, CDR storage retrieval (picture archiving communication systems-PACS)
- Stage 4: Computerised provider order entry (CPOE), support for evidence-based practice
- Stage 5: Barcode medication administration (BCMA), radio frequency identification (RFID) integrated with CPOE and pharmacy
- Stage 6: Full physician documentation, decision support, alerts, full PACS
- Stage 7: Fully electronic paperless environment

6.6.4 Attributes of Electronic Health Record (EHR)

The attributes of Electronic Health Record are listed below:

- Secure, reliable access where and when needed
- Records and manages episodic and longitudinal information
- Primary information source during care
- Assists with planning and delivery of evidence-based care
- Captures data for:
  - Quality improvement
  - Utilization review
  - Risk management
  - Resource planning
  - Performance management
- Captures information needed for medical record and reimbursement purposes
- Longitudinal, masked information supports clinical research, public health reporting, and population health initiatives
- Supports clinical trials and evidence-based research

6.6.5 Benefits of Electronic Health Record

The benefits of Electronic Health Record are tabulated and listed below:

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<th>S.No</th>
<th>Areas</th>
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<tbody>
<tr>
<td>1.</td>
<td>General</td>
<td>Improved data integrity: readable, better organised, accurate, complete</td>
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<td>Improved productivity: access data whenever, wherever for timely decision</td>
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<td>Increased quality of care: tailored views, “dash-board”</td>
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<td>Increased satisfaction for caregivers: easy access to client data and related services</td>
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<td>2.</td>
<td>Nursing</td>
<td>Decreased redundant data collection</td>
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<td>Allowed data comparison from prior visits</td>
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<td>Ongoing access, update record at bedside</td>
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<td>Improved documentation and quality of care</td>
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<td>Supported timely decision</td>
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<td>3.</td>
<td>Health provider</td>
<td>Better/faster/simultaneous data access</td>
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<td>Improved documentation, reporting</td>
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<td>Prompted to ensure administration of treatments and medications</td>
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<td>Supported automation of critical pathways / workflows</td>
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<td>Improved efficiency: eligibility, early warning of status changes</td>
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<td>4.</td>
<td>Healthcare Enterprise</td>
<td>Better record security</td>
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<td>Fewer lost records</td>
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<td>Instant notice of eligibility/procedure authorisation</td>
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<td>Decreased need and cost for record storage, x-ray film, filing</td>
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<td>Decreased length of stay due to waiting</td>
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<td>Faster turnaround for accounts</td>
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<td>Increased compliance with regulatory requirements</td>
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<td>5.</td>
<td>Patient</td>
<td>Decreased wait time for treatment</td>
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<td>Increased access/control over health information</td>
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<td>Increased use of best practices/decision support</td>
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<td>Increased ability to ask informed questions</td>
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<td>Quicker turnaround time for ordered treatments</td>
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<td>Greater clarity to discharge instruction</td>
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<td>Increased responsibility for own care</td>
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<td>Alerts and reminders for appointments and scheduled tests</td>
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<td>Increased satisfaction and understanding of choices</td>
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### 6.6.6 Advantages and Disadvantages of Electronic Health Record

The advantages of an EHR are listed below:

a) EHRs are easily accessible.
b) Easier to send a digital file from one office to another.
c) Time is saved in transferring files.
d) Accuracy of data are readily available for further decision making.
e) Readily available to patients when stored electronically.
f) Occupies less space in the office/file rooms.
g) Easier to store them for long term.
h) Reduces errors which arises from misinterpretation of bad handwritings.

### Disadvantages of Electronic Health Record

The disadvantages of an EHR are listed below:

a) Compromise on privacy of the health records of patients as it can be accessed by many.
b) To have error free maintenance, skilled technicians are required.
c) Details of the health records can be hacked.
d) Minimal error can lead to bigger loss as retrieval of data may be difficult if lost.
e) Is costly to set up the infrastructure.
f) Requires compatible system on board for all users.
g) Need to have a backup plan.

6.7 NURSES RESPONSIBILITY IN RECORD KEEPING AND REPORTING

Let us now discuss the nurses responsibility for records and reports as given below:

- Keep under safe custody of nurses.
- No individual sheet should be separated.
- Not accessible to patients and visitors.
- Strangers is not permitted to read records.
- Records are not handed over to the legal advisors without written permission of the administration.
- Handed carefully, not destroyed.
- Identified with bio-data of the patients such as name, age, admission number, diagnosis, etc. (Legal Issues)
- Never sent outside of the hospital without the written administrative permission.
- Patient Verification: Two identifiers: patient name and date of birth
- Compare to ID band, consents, diagnostic images, and all other patient documentation related to the procedure

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<thead>
<tr>
<th>Check Your Progress 2</th>
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<tbody>
<tr>
<td>1) What are the purposes of report writing?</td>
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<td>2) List the types of reports.</td>
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<td>3) List the benefits of electronic health records for nursing department.</td>
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6.8 LET US SUM UP

One of the foremost and important role of the nursing professionals is to accurately document their work so that it can be useful to all members of the health team in the interest of the client. A number of records and reports are maintained in the health centre. These are essential to check the progress of the clients, and the need to make accurate decisions when need arises.

6.9 KEY WORDS

<table>
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<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tr>
<td>BCMA</td>
<td>Barcode medication administration</td>
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<tr>
<td>CPOE</td>
<td>Computerised Provider Order Entry</td>
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<td>CDR</td>
<td>Clinical Data Repository</td>
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<td>EHR</td>
<td>Electronic Health Record</td>
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<tr>
<td>EMR</td>
<td>Electronic Medical Record</td>
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<tr>
<td>FRU</td>
<td>First Referral Unit</td>
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<td>IOM</td>
<td>Institute of Medicine</td>
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<tr>
<td>IUD</td>
<td>Intra Uterine Device</td>
</tr>
<tr>
<td>LAMA</td>
<td>Left Against Medical Advice</td>
</tr>
<tr>
<td>MCH</td>
<td>Maternal and Child Health</td>
</tr>
<tr>
<td>MTP</td>
<td>Medical Termination of Pregnancy</td>
</tr>
<tr>
<td>OP</td>
<td>Oral Pills</td>
</tr>
<tr>
<td>OPD</td>
<td>Out Patient Department</td>
</tr>
<tr>
<td>PACS</td>
<td>Picture Archiving Communication Systems</td>
</tr>
<tr>
<td>PID</td>
<td>Pelvic Inflammatory Disease</td>
</tr>
<tr>
<td>RFID</td>
<td>Radio Frequency Identification</td>
</tr>
<tr>
<td>RTI</td>
<td>Reproductive Tract Infection</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually Transmitted Infection</td>
</tr>
</tbody>
</table>

6.10 MODEL ANSWERS

Check Your Progress 1

1) **Purposes of record writing**

- Supply data that are essential for programme planning and evaluation.
- Provide the practitioner with data required for the application of professional services for the improvement of family’s health.
- Records are tools of communication between health workers, the family, and other development personnel.
- Health records shows the health problem in the family and other factors that affect health.
- A record indicates plans for future.
• Provides baseline data to estimate the long-term changes related to services.

2) **Types of Records**
   a) Cumulative or continuing records
   b) Family records

3) **Legal Implication of Records and Reports:**
   There are three approaches to legal implications of records and reports:
   • Individual approach: Records of importance are birth records, death records etc. They are valuable documents not only from health department also from other departments.
   • Community approach: Health records provide confirmation and protection of rights related to health. It presents charges through which charges can be taken against medical administration and political system. It could lead to proper implementation of services.
   • Nursing approach: It is important preserving individual records of health. Confidentiality and privacy has to be maintained. These documents should be shown to authorised person. The value of the record when they are presented at the right time. Legally accepted process should be followed for destroying obsolete records. Records of medico legal cases should be handled carefully.

4) **Principles of record writing**
   1) Nurses should develop their own method of expression and form in record writing.
   2) Records should be written clearly, legibly and appropriately.
   3) Records should contain facts based on observation, conversation and action.
   4) Select relevant facts and the recording should be neat, complete and uniform.
   5) Records should be written immediately after an interview.
   6) Records are confidential documents.
   7) Records are valuable legal documents and so it should be handled carefully, and accounted for.
   8) Records systems are essential for efficiency and uniformity of services.
   9) Records should provide for periodic summary to determine progress and to make future plans.

5) **Records to be kept under health centres**
   Family folders: MCH cards; Antenatal card/ postnatal cards; Infant card; Pre-school child card; Medicine distribution card include records of iron and folic acid distribution cards
   Family welfare records: Eligible couple, MTP, Family planning. Treatment and referral records, Vital event records: birth and death records
General information records: Individual records; Family records; Village records; Map of community

Other records: Antenatal records; medicine records; monthly/ yearly records; consumable stock register; stationary stock register; daily diary and cumulative records

Records to be kept with the Patient (Kept under supervision of CHN):
- health record of school going children; infant health card; maternal card;
- TB patient card; individual health card; birth and death record; inpatient and outpatient record and eligible couple records

6) **Register to be maintained in Health Centre**

- Village register; household survey register; eligible couple register; maternal and child health register and contraception register; sub-centre/FRU clinic register; death register; stock register; register for recording consultative process; referral register; daily diary.

7) **General guidelines for maintaining records**

1) Enter information in the proper place.

2) Write down information immediately as soon as possible. Delay results in incomplete and inaccurate records.

3) Maintain records up-to-date daily and avoid letting records being piled up.

4) Write clearly and neatly. It should be legible.

5) Keep records in order either alphabetically/numerically/geographically and with index card.

6) Keep all the registers in cupboard, dust regularly and protect from rats, cockroaches and termites.

7) Treat records confidential and do not allow unauthorized person to read the records.

8) Maintain an adequate stock of stationary, registers and all forms needed to be filled and submitted.

9) Destroy all old records (i.e. more than 5 years old).

**Check Your Progress 2**

1) Purposes of writing reports
   - To show the kind and quantity of service rendered over to a specific period.
   - To show the progress in reaching goals.
   - As an aid in studying health conditions.
   - As an aid in planning.
   - To interpret the services to the public and to other interested agencies.

2) Types of Reports
   1) Performance in corresponding month of last year
   2) Performance in the reporting month
3) Cumulative performance till corresponding month of last year
4) Cumulative performance till current month
5) Planned performance in current year

3) List the benefits of electronic health records for nursing department.
   1) Decreased redundant data collection
   2) Allowed data comparison from prior visits
   3) Ongoing access, update record at bedside
   4) Improved documentation and quality of care
   5) Supported timely decision

### 6.11 REFERENCES


