Content available at: https://www.ipinnovative.com/open-access-journals

The Journal of Community Health Management

Journal homepage: https://www.jchm.in/

Short Communication

Importance of the nurse's record

Y. Eben Jeya Roy[1,2,3]

[1]*American Health Information Management Association, United States of America*
[2]*Integrated Financial and Human Resources Management System, United States of America*
[3]*Institute of Health Records and Information Management, England*

ARTICLE INFO

Article history:
Received 12-04-2024
Accepted 06-05-2024
Available online 26-09-2024

1. Introduction

A written medical record must be maintained every person who has been admitted to the hospital as on in-patient, as on out-patient or as an emergency patient. The medical record documents the hospital experience of the patient.

2. The Main Purposes of the Medical Record Are to

1. Provide a means of communication between the physician another professionals contributing to the patient's care.
2. Serve as a basis for planning individual patient care.
3. Furnish documentary evidence of the course of the patient's illness and treatment during each hospital admission.
4. Serve as a basis for analysis study and evaluation of the quality of care rendered to the patient.
5. Assist in protecting the legal interests of the patient, hospital and physician.
6. Provide clinical data for use in case arch and education.

The skills of many medical and para medical specialists are required to give complete care to the patient. It is necessary that there be prompt recording of observation, treatment and care by are who contribute to the care of the patient.

A good medical record generally means a good medical care and an inadequate medical record generally reflects poor medical care.

Every hospital, through its medical, nursing and other personnel endeavors to provide the best possible care for patient. A major consideration toward that goal is the nursing service of the hospital. The nurse generally is more frequently in touch with the patient than the others who are interested in his welfares. It is this intimate and constant contract that gives, her so vital, a role in his care.

3. Major Sections

3.1. The are three major sections of the patient medical record

1. **Identification of Sociological Sections:** This section covers administrative and personnel data. The requisite information is obtained in the admitting office and is recorded on the following forms: (a) Admission record (b) summary sheet (c) patients Index card (d) patient register.
2. **Medical Section:** This section contains statements on the studies observation conclusions and activities of the attending physician and the residents working under his and any physician who was consulted. This information is recorded under the following headings: chief complaint, present illness, post illness,

E-mail address: ebenjeyaroy@yahoo.co.in (Y. Eben Jeya Roy).

https://doi.org/10.18231/j.jchm.2024.027

full history, social history, systemic review, physical examination, other medical reports (to include x-ray, clinical laboratory, consultation, anaesthesia, operation or treatment, physical therapy and any other reports for a particular case, progress motor, Doctor's order, discharge summary.

3. **Nurses Section:** The nurses are responsible for this section of the medical record. It is a report of their observation and care of the patient as directed by the physician. The data are recorded on the following forms. Nurses records, Nurse's observation chart, composite (T.P.R) graphic chart, intake and output (daily fluid balance chart). Chart for special cases (e.g. Diabetic chart).

4. Nurse's Records

One of the primary responsibilities of the hospital in the proper care of the sick and injured is to provide accurate and adequate medical records, and one of the important contribution to them is the nurses notes. The patient's nursing record is a document which may not only aid in diagnosis of a specific case, but may aid in the treatment of other cases, and it is also of value.

Good nursing service implies expert observation. Accurate and complete clinical recording is an extension of efficient nursing, and ability to do such recording is a qualification of the efficient nurse. Clinical receding requires or accuracy, promptness in reporting developments and careful itemization of services performed incarrying out the doctor's order (the orders of the doctor) should be in writing. If an order is telephoned, the nurse should made certain that the physician signs the order on his next visit for the welfare and comfort of the patient. The same nurses are not on duty constantly during the day and night. One who has observed an important development may be off duty or attending another patient at the time of the doctors visit, or she may forget about the observation entirely. As such every important observation should be recorded. There is as much value in the elimination of unnecessary detail as in the inclusion of important and pertinent points.

Every observation should be recorded immediately but a treatment should never he charted before it is done. The nurse who 'closes' a chart at mid night, who guesses at a temperature and records it or deliberately make or false statement on a record, violates the trust placed in her. All nurse's notes should be signed by the nurse who rendered the service.

Medical records are now preserved for more than ten years and in some cases permanently for future reference and study and for medico-legal protection. As such they should be comprehensive, logical, accurate, and legible with nothing recorded but facts. In medico- legal controversies nurse's notes are of immerse value as evidence of medical treatment and nursing care.

4.1. The nurse's record services four major purposes

1. As a record of the patient's and eliminator of errors.
2. As a time saver for doctors and eliminator of errors.
3. As a proof for the work done.
4. To complete the medical record.

5. Nurse's Observation Chart

Nursing staff in intensive care units or recovery rooms should use this form to do progress estimates of the various physiological indications shown in the columns concerning seriously and dangerously ill patients under their care. This record facilities the doctor to more the up-to-date data,

6. Graphic (T.P.R.) Chart

This record is initiated in the ward on admission of the patients. It serves to give the doctor or quick picture of the temperature, pulse and respiration of his patient during his absence it also provides the space for recording blood pressure, bowel, urine, sputum, weight, etc. This form could serve the purposes of an intensive care unit as well as general nursing area.

7. In Take and Out Put Chart

Recording of intake and output should be done as indicated. At the end of 24 hours two red lines should be drown and in between these lines, the total 24-hours intake and output should be recorded. Provision is also mode, at the foot of the form, for estimates of the current electrolyte balance and on the back for orders for intravenous and oral administration of fluids.

8. Chart for Special Cases

(e.g. Diabetic Chart): There are many special forms. For instance, take diabetic chart, in which space is provided at the head of the form for energy of relevant notes on current therapy, including insulin and diet. Graphic presentation can be made below of the sugar statements of a patient's urine and statements can be given on acetones present, insulin dosage, blood sugar content etc.

In brief, the Nurse's record is actually a signed statement of her treatment of the patient. The bedside notes recount the reasons for a given treatment and how the nurse carried out the doctor's orders. Emergency cases, particularly of medico-legal nature, many of which eventually involve claims for damages, make imperative an accurate word picture of treatment and convalescence.

9. Other Observations Which Contribute to the Usefulness of the Record are

(1) Identification of the patient and the treating doctor, (2) how admitted-by wheel chair, ambulance or ambulatory, (3)

complete recording of condition of patient on admission and on discharge, nothing any mark bruise, born, rash or irritation, (4) recording of admission temperature, pulse and respiration, (5) routine and special procedures, (6) medication special dosage and manner of administration, (7) Objective and subjective symptoms, (8) changes in appearance and mental condition, (9) complaints and (10) signature of nurse who renders the service.

The nurse's record is the part of patient medical record which in a large sense is a compilation of scientific data derived from many sources, co-ordinated into a document and available for various uses, personal and impersonal, to serve the patient, the doctor, nurse other professional personnel, the institution in which the patient has been treated, the science of medicine and society as a whole.

9.1. Nurses notes

The nurses notes are used by nursing personnel to record their observation about the patient and the nursing care they have given the patient. In other words they give a chronological picture of the nursing care and the patients reaction to it. Nurses notes service as a means of communication between nursing personnel and the physician.

9.2. The nurses notes serve four major purposes

1. **As record of the patient's condition during the physician's absence:** It is a record of pertinent facts supplied by the nurses, giving the physician a clear perspective of his patient's progress during his absence from the hospital. This entire plan of treatment may depend upon the information recorded. With the help of intelligently recorded nurse's notes, the physician should be able to watch his patient's progress even though he visits the hospital but once a day.
2. **As a time saver for the physician and an eliminator of errors:** If no written record of the patient's hour - to hour progress were available, each person attending the patient would have to be told individually the details of the case. Thus, not only much time, be lost, but more unfortunately such verbal instructions might result in errors in medication or other treatment.
3. **A s proof of work done:** It is essential for the nurse to record work done as ordered by the physician so that he may note the results and determine the future course of treatment. If used as evidence in a legal case, the nurses notes would serve to substantiate the care given as well as to indicate the patients reaction to care given.
4. **To complete the medical record:** Nurses notes serves to complete the information in the medical record discharge records may be used for group studies, research and reference or re- admission of the patient in subsequent illness. To be useful they must give a complete day to day report of progress.

10. Source of Funding

None.

11. Conflict of Interest

None.

Author biography

Y. Eben Jeya Roy, Consultant in Medical Records

Cite this article: Eben Jeya Roy Y. Importance of the nurse's record. *J Community Health Manag* 2024;11(3):165-167.