FUNDAMENTALS OF NURSING

LECTURE 07

NURSING INSTITUTE JHENAIDAH

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NURSING RECORDS or DOCUMENTATION

Question:

✦ **Define Nursing Records or Documentation.**

Nursing Records or Documentation:

Concepts: The primary reason for documenting the initial assessment is to provide the health care team with a data base that becomes the foundation for the intire nursing process. It helps in the identification of health problems and aids in the formulation of nursing diagnostic statements to plan immediate and ongoing intervention may result.

The initial and ongoing assessment documentation database also establishes a way to communicate with the multidisciplinary team members.

Question:

✦ **What is documentation?**

Documentation:

Documentation is a form record keeping and nursing action that produces a written and/or electronic account of pertinent client data, nursing clinical decisions and interventions, and the client's responses in a health record. Documentation is an integral part of professional nursing and safe practice.

Question:

✦ **What are the importance/Significant of good record keeping and documentation?**

Important or Significant of Records or Documentation:

A. For the individual and family:
    a) Serve the history of the client.
    b) Assist in continuity of care.
    c) Evidence to support if legal issues arise.
    d) Assess health needs, research and teaching.

B. For the Doctor:

a) Serve the guide for diagnosis, treatment, follow up and evaluation- Indicate progress and continuity of care.

b) Self evaluation of medical practice.

c) Protect doctor in legal issues.

d) Used for teaching and research.

C. For the nurses:

a) Document nursing service rendered.

b) Shows progress- Planning and evaluation of service for future improvement.

c) Guide for professional growth- Judge the quality and quantity of work done.

d) Communication tool between nurse and other staff involved in the care.

e) Indicate plan for future e recording system.

Question:

✦ **Describe different types of Nursing Records.**

Nursing records:

1. Data collection from (Patient history)
2. Kardex.
3. Nursing notes.

1. Data collection from (Patient history):-

It includes data of admission, contact emergency, personal data physician's name, socio- economic background, present and past health history, chief complain, diagnosis, treatment and consequences (Discharge or death).

2. Cardex:- Cardex is a series of flip cards usually kept in a portable file. It includes-

(a) Patient demographic data, such as- name, age, occupation, religion, physician, admission date, diagnosis major procedures, surgery, and emergency contact.

(b) Basic need, such as diet, activity, hygiene, how bowel and urinary elimination is accomplished, assertive devices, and safety precaution.

(c) Allergies.

(d) Diagnostic tests.

(e) Daily nursing procedures, such as dressing changes, vital signs and irrigations.

(f) Medication and intravenous I/V therapy.

(g) Respiratory therapy, such as use of oxygen, mechanical ventilation or suctioning.

Nursing Notes: Nursing progress notes are recorded for all clients, but vary in format depending on the setting. Narrative notes. SOAP notes, (Subjective, Objective, Assessment, plan). DAR notes (Data Action Response) and PIE notes (Problem, Intervention and Evaluation) are all descriptive forms of documentation that summarize nursing assessment, interventions and client responses.