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A TRAINING COURSE IN WOMEN'S HEALTH

**Module Eleven**

The Day-to-Day  
Nursing Management of  
Health Units  
Part Two

## **International Prototype**

Developed by the Institute for Development Training, this manual, and others in the series, is intended as a prototype only. For effective use in training programs, a country adaptation focused on the needs of a specific type of trainee, followed by pre-testing, is considered essential. For information on sources of funding for adaptation workshops, pre-tests and multiple copies of the adapted manual contact:

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## Introduction to Module Eleven – Part Two

Head nurses are the first line representatives of health care institutions. Their position is one of central leadership in the nursing organization revolving around major areas of patient care management, human resource management, and operational management.

A well-administered health unit in which reports are complete, medical and nursing orders are properly transcribed, equipment and supplies are available in good order, and the environment is controlled, depends to a large extent on the head nurse's ability and efficiency.

This self-instructional module will provide you with the information you need about operational management activities performed by the head nurse in relation to nursing records and reports, nursing recording, equipment and paperwork. This information should enable you to perform these activities efficiently and to help others to learn them.

This module can be used in its present self-instructional format for individualized training. It can also be used by trainers as background information for group training sessions and demonstrations.

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## Instructions for the Learner

This module, which is one of a series of modules, is self-instructional. Self-instruction is a method by which you, the learner, learn by yourself from carefully sequenced materials. The module is divided into short sections of information and each of these sections is followed by a series of questions which give you a chance to practice using the information you have learned. Answers to these questions are given so that you can check your understanding of the information.

The self-instructional method allows you to learn at your own speed and enables you to check your progress as you learn the information.

Follow the steps below in order to proceed through this self-instructional module in the most effective way:

1. Read the objectives for the module. They will outline for you what you will learn and be able to do after completing the module.
2. Take the Pre-test to get an idea of what you already know and what you need to learn.
3. Read and study the information in Section 1.
4. Answer the practice questions following the section without looking back at the information. Use a separate sheet of paper.
5. Check your answers using the answer sheet on the page following the questions.
6. If any of your answers are incorrect, reread the information in the section and try to answer the questions again.
7. When all your answers are correct, go on to the next section.
8. Proceed through the rest of the sections in the same way: read section; answer questions; check answers; reread section if necessary.
9. Take the Post-test after you have completed the entire module.
10. Check your answers to the Post-test using the answer sheet at the end of the module.

# Prerequisites and Objectives

## Prerequisites

This module has been prepared for the nurse who has a Technical Nursing Diploma degree or higher and who occupies the position of head nurse in a health unit. This module does not require the learner to have any additional skills or background information.

## Main Learning Objectives:

After completing this module, the learner will be able to describe the operational management activities performed by the head nurse in relation to nursing records and reports, nursing recording, and equipment and paperwork.

## Sub-objectives:

The following sub-objectives are the individual skills that will enable you to perform the main objective listed above. You will learn these enabling skills in the 6 information sections that make up this module. The sub-objectives, or skills to be learned in an information section, will be listed again at the beginning of each section. After you complete the 6 information sections, you will be able to do the following:

1. state the eight important advantages of records and reports;
2. list the characteristics of good recording and reporting;
3. list the types of reports used by the nursing staff in health units;
4. list the items that the head nurse includes in her daily report to the director of the health unit;
5. list the information items that should be included in the daily shift report;
6. state the points that should be included in the emergency report and incident report;
7. state the points that should be included in the administrative report;
8. list seven types of records used in the nursing units;
9. identify the records used by the nursing staff in the health units;
10. state the reason for using each type of record;

11. define the nurse's and the head nurse's responsibility in keeping patients' records;
12. explain how the quality of nursing care can be improved through record keeping;
13. list the steps that a nurse follows in recording the nursing care delivered to the patient;
14. give examples of the baseline information that a nurse should collect from a pregnant patient;
15. give examples of the information that a nurse should collect from a pregnant patient with a health problem;
16. determine the necessary nursing care required for each identified health problem;
17. explain why it is important for the head nurse to be familiar with the instructions concerning the stock and storage of inventory;
18. identify the method used to assess the health unit's needs for equipment, instruments, and supplies;
19. determine the methods for obtaining needed equipment and supplies;
20. identify the types of inventories;
21. state the nurse's and the head nurse's role in the maintenance of equipment and instruments;
22. explain the reason for having an inventory of articles and equipment present in the health unit;
23. determine the paperwork that is included in each of the activities that take place in the health unit;
24. write a patient referral letter to another health unit;
25. state the importance of having a special system for keeping files and records;
26. state the characteristics of a good filing system;
27. identify the four methods used in filing;
28. explain the reason for arranging and indexing the filing system; and
29. give an example of how to make an index for a health unit filing system and give the best place for keeping and storing files.

## Pre-Test

**To the Learner:** Before starting this module, try taking the following test. This test will give you an idea of what you already know and what you will learn in this module. You will take the same test again after you have completed the module. A comparison of your two sets of answers will give you an idea of how much you have learned from this module.

1. State the eight important benefits of records and reports.
2. List the characteristics of good reporting and recording.
3. List the types of reports used by the nursing staff in the health units.
4. List the items that the head nurse includes in her daily report to the director of the health unit.
5. List the information that should be included on the daily shift report.
6. State the points that should be included in the accident and incident report.
7. State the points that should be included in the administrative report.
8. List the seven types of records used in nursing units.
9. Following is a list of sentences that describe the different kinds of records used in health units. Give the name of the record that corresponds with each sentence.
  - a. This record includes the name of the patient as well as the nursing staff responsible for providing nursing care for this patient and the duties assigned to each nurse.
  - b. This is a record of all the instruments, furniture, and equipment. The record also includes the quantity, condition, and specifications of the listed articles.
  - c. This document indicates the type of health care delivered to the patient. It also includes all the information concerning the patient since his first admission to the unit.
  - d. This record is prepared weekly or daily and includes the plan for nursing coverage for the health unit over a 24-hour period.
  - e. This record includes the observations of the patient's health condition as well as the nursing care given to him.
  - f. This record is used to evaluate personnel performance yearly or every six months.

10. Give two purposes for using each of the following records:
  - a. patient record
  - b. nurse's notes
  - c. personnel performance appraisal
  - d. duty roster
  - e. inventory record
11. Explain the nurse's and the head nurse's responsibilities for keeping patients' records.
12. Explain how a nurse can improve the quality of nursing care through nursing recording.
13. List the steps that a nurse follows for recording the nursing care delivered to her patients.
14. A pregnant woman visits the health unit.
  - a. What baseline information should the nurse obtain from the patient?
  - b. Give examples of the health problems that you may suspect from the primary information you have gathered.
15. Explain why the head nurse must be familiar with the instructions concerning the stock and storage of inventory.
16. What is the head nurse's role in determining the unit's needs for equipment and instruments?
17. Identify the methods used for obtaining supplies and equipment.
18. List the types of inventory custody in the health unit.
19. State the problems that the nurses have from keeping custody of inventories.
20. What is the nurse's role in maintaining equipment and instruments?
21. What is the purpose of having a yearly inventory inspection?
22. What is the head nurse's role in disposing of old articles?
23. List the paperwork included in the following activities and the personnel responsible for completing it:
  - a. pre-natal care
  - b. statistics and reports
  - c. requests
  - d. neo-natal care
  - e. follow-up patients

24. Write the important points that should be included in a referral letter concerning the patient's condition.
25. What is the importance of having a particular system for filing records?
26. What are the characteristics of a good filing system?
27. Following are four phrases which describe the four methods for filing. Give the name of the method that corresponds with each phrase.
  - a. filing according to the information concerning each village or district
  - b. filing according to the subject
  - c. filing according to the first letter of the employee's or the patient's name
  - d. filing according to the numbers assigned to the patients or other individuals
28. What is the purpose of having an index for files?
29. Complete the following office index by giving the right place for keeping the following documents and information:
  - a. patients' discharge file
  - b. vaccination cards
  - c. administration letters

## 1. Records and Reports

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### Learning Objectives:

At the end of this information section, you will be able to:

1. state the eight most important advantages of records and reports; and
  2. list the characteristics of good records and reports.
- 

The work of the various categories of nursing personnel (inspectors, supervisors, head nurses, and nurses) needs to be written in reports and patient care data need to be recorded. Records and reports have many advantages which are summarized in the following statements:

1. They provide quantitative as well as qualitative records of the unit and nursing activities that can be referred to whenever necessary.
2. They are one of the means that can be used to evaluate personnel performance in the health unit.
3. They are a method of communication between the employees and their supervisors.
4. They provide indicators that help in planning for health and nursing services.
5. They provide indicators that help in organizing educational and training programs.
6. They are one of the tools used to determine the communities' health status, problems, and the prevalent disease and their treatments.
7. They provide a tool for comparative studies in the fields of nursing and public health.
8. They are dependable documents used in legal cases to protect health institutions and personnel.

**Characteristics of good reporting and recording are:**

1. accurate, clear and honest documentation.
2. complete, correct and objective information chronologically organized.
3. punctuality when reporting important information, accidents, or disasters.
4. The report should be signed and dated including the time, if necessary.

### Practice Questions

1. State the eight most important benefits of records and reports.
2. List the characteristics of good reporting and recording.

To the Learner: Turn the page to check the answers.

## Answers to Practice Questions

1.
  - a) They provide qualitative as well as quantitative records of the unit and nursing activities that can be referred to whenever necessary.
  - b) They are one of the means that can be used to evaluate the personnel performance.
  - c) They are a method of communication between the employees and their superiors.
  - d) They provide indicators that help when planning for health and nursing services.
  - e) They provide indicators that help in organizing educational and training programs.
  - f) They are one of the tools used to determine the communities' health status problems, and the prevalent diseases and their treatments.
  - g) They provide a tool for comparative studies in the fields of nursing and public health.
  - h) They are dependable documents used in legal cases to protect health institutions and personnel.
  
2. The characteristics of a good report and record are:
  - a) accurate, clear and honest documentation.
  - b) complete, correct and objective information chronologically organized.
  - c) punctuality when reporting important information, accidents, or disasters.
  - d) The report should be signed and dated including the time, if necessary.

To the Learner: If you missed any of the answers to the questions, go back to the information section and study it again. When all of your answers are correct, go to section 2 on the next page.

## 2. Nursing Services Reports

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### Learning Objectives:

At the end of this information section, you will be able to:

1. list the types of reports used by the nursing staff in health units;
  2. list the items that the head nurse includes in her daily report to the director of the health unit;
  3. list the information that should be included in the daily shift report;
  4. state the points that should be included in the emergency report and incident report; and
  5. state the points that should be included in the administrative report.
- 

The types of reports used by the nursing staff include:

1. Daily report
2. Shift report
3. Patient census report
4. Work problems and follow-up on the suggested solutions report
5. Accident and incident report
6. Patient complaints report
7. Administrative report

### 1. Daily report:

This report is written by the head nurse to the director of the health unit. The report should be delivered in the morning after the head nurse's rounds and should include:

- a) The general condition of the unit
- b) The patient and/or the consumer census

- c) The patients who have changes in their conditions or who developed complications or who had accidents and the procedures done for them
- d) Admission cases, discharges, transfers, and deaths
- e) Critical cases during the previous evening and the night shift
- f) Patients' complaints

2. Shift report:

This report is a way of communicating and following up on information from one group of nurses to another on a 24 hour basis. These reports provide the nurse with the observed changes in the patients' conditions and what happened to them during the previous shift period.

The shift report includes the following:

- a) Critical cases (hemorrhage, fevers, comas, postoperative cases, convulsions) and the nursing care provided.
- b) Newly admitted cases.
- c) The administrative part of the report which includes the number of nurses on the shift and the absenteeism.

3. Patient census report:

This reports the number of patients in the in-patient department of a health unit or the in-patient unit of a hospital at a given time, which is usually midnight. The on-duty night nurse is the one who is responsible for writing this report. The purpose of the report is to give the number of patients in the in-patient units and the percentage of occupied beds and the number of unoccupied beds.

4. Work problems and follow-up on the suggested solutions reports:

These reports are an effective tool to obtain facts and help to direct the discussion of a specific problem in meetings as well as give directions to the follow-up system.

The following should be done when writing a report concerning the work problems:

- a) Identify the problem and its size.

- b) Give an accurate statement about the problem and what needs to be corrected.
- c) Analyze the reasons that led to these problems or mistakes. Give an account of the roots of the problem as seen by the reporter.
- d) Suggest the solutions and the persons who can achieve these solutions.

5. Accident and incident reports:

The patients' safety and comfort are part of the nursing staff's responsibilities in the health unit. They are responsible for avoiding accidents and danger and controlling infectious cases that may occur in the health units.

To ensure a healthy and safe environment inside hospitals and health units, the nursing staff should perform their duties in a way that minimizes the occurrence of health hazards or mistakes (fires, electric shock, infections, accidents).

One of the most important duties of the nursing department in hospitals and health units is to follow a special system to report any mistakes or accidents when they occur. The nurses should be trained in how to report incidents and accidents when they occur. One of the best ways to do so is writing an incident or accident report. These reports are used as references whenever any questions concerning the nursing care arise or when treatment has been prolonged longer than normal. These reports are written to ensure the safety of patients as well as nurses and can be used as a legal document.

Incident reports for incorrect medications or complications:

These mistakes might be made by the individuals who issue, store or give medications to patients (nursing staff, pharmacist, medical technician).

These mistakes occur for the following reasons:

1. Unclear and inaccurate writing of doctor's orders.
2. Giving verbal orders concerning patient's medication.
3. Unclear writing of the directions for usage of the medications dispensed by the pharmacy.
4. Not following the operating room instructions written by the head nurse. These instructions should be followed by both nursing staff and doctors.

5. Not following the proper work procedures and manuals.

The incident reports include:

1. Name of the patient and diagnosis
2. Date of admission or visit
3. The time when the incident was noticed and the time it was reported
4. What was done to prevent the incident
5. Explanation of the circumstances under which this incident occurred
6. What steps were taken to correct the mistake
7. The date and signature of the reporter
8. The head nurse's suggestions to prevent the recurrence of this mistake

(This report is to be sent to the hospital or health unit director).

#### 6. Patient complaints reports:

Patient complaints should be reported immediately to the head nurse. It is important that the nurses recognize the patient's complaints from the start so that the suitable solutions and the nursing plans can be implemented at the appropriate time.

The patients' and their relatives' complaints concerning the quality of services provided should be considered as active participation in directing these services towards the benefit of the patient and staff as well as the unit organization. It is the duty of the nursing staff to look objectively at the patient's complaints and help them comply with their treatments.

This report includes the following:

- a) The complaints and their causes as stated by the patient
- b) The steps taken to eliminate the complaints
- c) The results
- d) Date and signature

**7. Administrative reports:**

Sometimes it is required that every department or unit submit a monthly, quarterly, or yearly report. For example, the head nurse is requested to write a report periodically about work conditions in the unit and submit it to the nurse inspector.

This report includes the following:

- a) Brief summary about the unit activities, nursing personnel, number of working hours, shifts, statistics concerning number of deliveries, admitted and discharged cases and number of deaths as well as number of home visits.
- b) The available resources such as instruments, equipment and maintenance facilities.
- c) The obstacles that affect the nursing care in relation to manpower, environment, equipment and instruments.
- d) The reasons for changing work routines, personnel or resources and the results of these changes.

### Practice Questions

1. List the types of reports used by the nursing staff in the health units.
2. List the items that the head nurse includes in her daily report to the director of the health unit.
3. List the information that should be included on the daily shift report.
4. State the points that should be included in the accident and incident reports.
5. State the points that should be included in the administrative report.

To the Learner: Turn the page and check your answers.

## Answers to Practice Questions

1. The types of reports are:
  - a) Daily report
  - b) Shift report
  - c) Patient census report
  - d) Work problems and follow-up on suggested solutions report
  - e) Accident and incident report
  - f) Patient complaints report
  - g) Administrative report
2. The head nurse should include the following data in her report to the director of the health clinic:
  - a) The general condition of the unit.
  - b) The patient and the consumer census.
  - c) The patients who have changes in their conditions or who developed complications and the procedures done for them.
  - d) Admission cases, discharges, transfers, and deaths.
  - e) Critical cases during the previous evening and the night shift.
  - f) Patients' complaints.
3. The shift report includes the following:
  - a) Critical cases and nursing care provided.
  - b) Newly admitted cases.
  - c) The administrative part of the report which includes the number of nurses on the shift and the absenteeism.
4. Accident and incident reports should include:
  - a) Name of the patient and diagnosis
  - b) Date of admission or visit
  - c) The time when the incident was noticed and the time it was reported
  - d) What was done to prevent the incident
  - e) Explanation of the circumstances under which this incident occurred
  - f) What steps were taken to correct the mistake
  - g) The date and signature of the reporter
  - h) The head nurse's suggestions to prevent the recurrence of this mistake
5. The administrative report includes the following:
  - a) Brief summary about the unit activities, nursing personnel, number of working hours, shifts, statistics concerning number of deliveries, admitted and discharged cases and number of deaths.
  - b) The available resources such as instruments, equipment and

- maintenance facilities.
- c) The obstacles that affect the nursing care in relation to manpower, environment, equipment and instruments.
  - d) The reasons for changing work routines, personnel, or resources and the results of these changes.

**To the Learner:** If you missed any of the answers to the questions, go back to the information section and study it again. When all of your answers are correct, go to section 3 on the next page.

### 3. Records

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#### Learning Objectives:

At the end of this information section you will be able to:

1. list seven types of records used in the nursing units;
  2. identify the records used by the nursing staff in the health units;
  3. state the reason for using each record; and
  4. define the nurse's and the head nurse's responsibility in keeping patients' records.
- 

Records are an administrative tool used to keep and classify information. Records help to achieve the management objectives as well as to share in the education process and scientific research.

The following are the different types of records used in nursing units:

1. Patient records
2. Nurse's notes
3. Nursing staff work assignment sheets
4. Duty rosters
5. Inventory record
6. Time tables
7. Personnel performance appraisal

#### 1. Patient records:

This document indicates the type of health care provided to the patients. It contains all the information concerning the patient since his first visit or admission to the health unit. It also contains his lab tests, observations, therapeutic procedures, and patient response to treatment and services performed.

The patient record (file) is used for the following purposes:

- a) to help reach a diagnosis and treatment.
- b) to record the services provided to the patient.
- c) to share in teaching and scientific research.
- d) to serve as a legal document.
- e) to evaluate the medical and nursing care provided to the patient.

### **The nurse's responsibilities towards patient records:**

The nurse organizes the new patient's records and sees that it contains the following documents and information:

- a) Patient's personal data.
- b) Vital signs chart and the nurse's notes forms.
- c) Labs, x-rays and other department forms.
- d) Treatment and physician orders forms.

### **The head nurse's responsibility towards keeping patients records:**

- a) The records should be kept in a safe place.
- b) The records should not be given to anyone except to the treating physician, or in the case of a scientific study or for transferring a patient.
- c) Forms should never be removed from the patient's file for any reasons.
- d) The patient's relatives or friends are not allowed to see the patient's files except by written permission from the hospital or health unit director.
- e) Instructions and training should be given new nurses on how to write complete and correct nursing notes.
- f) Before the patient's discharge, the head nurse should make sure that inpatient record is complete and correctly organized before it is sent to the medical records department.

## **2. Nurse's notes:**

Nurse's notes include the nurse's observations of the patient's condition and the nursing care delivered to him. They also contain all the information concerning treatment, medication, diet and health instructions. They should also contain the physical and psychological status of the patient and the patient's response to treatment and changes in his condition.

The purpose of this record is:

- a) to have a standardized record that is agreed upon by all personnel working in the unit for writing the nurse's notes. This will make it easy to transfer the patient care responsibilities from one nurse to another during the different working hours.
- b) to facilitate a fast review of the patient's condition as well as the nursing care provided.
- c) to emphasize the importance of documenting the nurse's observations.

## **3. Nursing staff work assignment sheets:**

These forms include the names of the nursing staff working in the unit and the names of the patients under their care as well as the duties

of each nurse. These should be a standardized form that is to be filled by the head nurse every day. This record is to be placed in a specific place that everybody knows.

The purpose of this record is:

- a) to inform the nursing staff in writing about their daily duties.
- b) to list the nurses responsibility for each patient.
- c) to provide a basis for evaluating the nursing care delivered to each patient.

#### 4. Duty roster:

This record is prepared weekly or daily to outline the nursing plan to cover the unit with 24-hour nursing staff. It should include the following:

- a) Names of the nursing staff.
- b) The different levels of the nursing staff present in the different shifts over the 24-hour period.
- c) The name of the head nurse on each shift.
- d) Meeting times and lunch hours.
- e) Days off, sick leave, permission notes, and absenteeism.

The purpose of this record is:

- a) To show the nursing coverage of the unit over the 24-hour period.
- b) To have a daily absentee record of the nursing staff.
- c) To give information about the different nursing service in relation to the number and level of manpower.
- d) To show the number of working hours for each nurse.

#### 5. Inventory records:

These are labeled records listing all of the equipment, furniture, and instruments as well as their quantity, quality and condition.

The purpose of this record is:

- a) To supply the head nurse with information regarding missing instruments and broken or old instruments that need disposal.
- b) To be able to return any excess supplies and borrowed instruments to the right place before inventory inspection.

#### 6. Time tables:

Time tables are records of routine and irregular work.

The purpose of this record is to provide the time for daily, weekly, and monthly activities.

- a) The daily time tables provide the time schedules for the routine activities.
- b) The monthly time schedules include the monthly reports, supplies, orders, etc.

#### 7. Personnel performance appraisal:

These are records used to evaluate the personnel performance on yearly or half-yearly basis

The purpose of these records is:

- a) to serve as a baseline for promoting or rewarding personnel.
- b) to serve as an incentive for professional progress.
- c) to provide reasons for poor performance and recommendations for achieving higher performances.

## Practice Questions

1. List seven types of records used in nursing stations.
2. Following is a list of sentences that describe the different kinds of records used in health units. Give the name of the record that corresponds with each sentence.
  - a) This record includes the name of the patient as well as the nursing staff responsible for providing the nursing care for this patient and the duties assigned to each nurse.
  - b) This is a record of all the instruments, furniture and equipment. This record also includes the quantity, condition and specifications of the listed articles.
  - c) This document indicates the kind of health care delivered to the patient. It also includes all the information concerning the patient since his first admission to the hospital.
  - d) This record is prepared weekly or daily and includes the plan for nursing coverage for the health unit over a 24-hour period.
  - e) This record includes the observations of the patient's health condition as well as the nursing care given to him.
  - f) This record is used to evaluate personnel performance yearly or every 6 months.
3. Give two purposes for using each of the following records:
  - a) Patient record
  - b) Nurse's notes
  - c) Personnel performance appraisal
  - d) Duty roster
  - e) Inventory record
4. Explain the nurse's and the head nurse's responsibilities for keeping patient's records.

To the Learner: Turn the page to check your answers.

## Answers to Practice Questions

1. The seven records in nursing units are:
  - a) Patient records
  - b) Nurse's notes
  - c) Nursing work assignment sheets
  - d) Duty roster
  - e) Inventory record
  - f) Time tables
  - g) Personnel performance appraisal
2.
  - a) Nursing staff work assignment sheet
  - b) Inventory record
  - c) Patient record
  - d) Duty roster
  - e) Nurse's notes
  - f) Personnel performance appraisal
3.
  - a) Purpose of Patient record:  
Helps reach a diagnosis and treatment.  
Records the services provided to the patient.
  - b) Purpose of Nurse's notes:  
To have a standardized record for writing the nurse's notes that is agreed upon by all personnel working in the clinic. This will make it easy to transfer patient care responsibilities from one nurse to another during the different working hours.  
To facilitate fast review of the patient's condition as well as the nursing care provided.
  - c) Purpose of Personnel performance appraisal:  
To provide baselines for promoting or rewarding personnel.  
To serve as an incentive for professional progress.
  - d) Purpose of Nursing staff work assignment sheets:  
To inform the nursing staff about their daily duties in writing.  
To list the nurses responsible for each patient.
  - e) Purpose of Inventory records:  
To supply the head nurse with information regarding missing instruments and broken or old instruments that need disposal.  
To be able to return any excess supplies to the right place.
  - f) Purpose of Duty rosters:  
To show the nursing coverage of the unit over a 24-hour period.  
To keep a daily absentee record of the nursing staff.
4.
  - a) The nurse's responsibilities towards the patients records are:
    - 1) organizing the new patients records and seeing that it contains

- the necessary documents and forms.
- 2) recording the vital signs and writing the nurse's observations.
- b) The head nurse's responsibilities towards keeping patients records are:
- 1) the records should be kept in a safe place.
  - 2) the records should not be given to anyone except to the treating physician or in a case of scientific duties or transferring of a patient.
  - 3) forms should never be removed from patient's files for any reasons.
  - 4) the patient's relatives or friends are not allowed to see the patient's files except by written permission from the hospital or health unit director.
  - 5) instructions and training should be given to new nurses on how to write complete and correct nursing notes.
  - 6) before the patient's discharge, the head nurse should make sure that the patient's record is complete and correctly organized before it is sent to the medical records department.

**To the Learner:** If you missed any of the answers to the questions, go back to the information section and study it again. When all of your answers are correct, go to section 4 on the next page.

## 4. Nursing Recording

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### Learning Objectives

At the end of this information section, you will be able to:

1. explain how the quality of nursing care can be improved through record keeping;
  2. list the steps that a nurse could follow in recording the nursing care delivered to the patient;
  3. give examples of the baseline information that a nurse should collect from a pregnant patient;
  4. give examples of the information that a nurse should collect from a pregnant patient with a health problem; and
  5. determine the necessary nursing care required for each identified health problem.
- 

Nursing care can be greatly improved if nurses precisely record all the information and the data concerning the patient's conditions, needs and treatment so that this information can be retrieved whenever necessary.

### How to record nursing care:

There is a simplified method to record nursing care for all patients. The following steps outline the method:

#### 1. Collect baseline information:

These are the data that have been collected by the nurse during her first meeting with the patient. These data include the primary assessment of the patient's condition on his first admission to the hospital or health unit.

#### 2. Identify the health, psychological and social problems of the patient.

These problems are to be recorded by the head nurse or the nurse who is taking care of the patient. These problems are obtained from the first visit data. They should be classified chronologically as well as according to their importance. Data to be included are: diagnosis, signs and symptoms, lab investigations, environmental influences, psychological

and social problems. These problems are given numbers to facilitate nursing recording in the nurse's notes.

3. Determine the direct nursing care for each identified problem.

The nursing care required for each problem is determined by the head nurse. Written instructions are to be given to the nurses who take care of the patient.

4. Follow up the patient's condition through the nurse's notes.

All facts and information related to the progress of the patient's condition should be recorded. Objective information which the nurse observes and measures as well as subject information which the patient feels and expresses should be recorded. Sometimes a flow chart can be used for recording repeated information.

5. Write the discharge summary:

The patient's health and psychological condition is recorded at the time of his discharge.

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A model of the steps used to record the nursing care  
for a pregnant woman

Care of the mother during pregnancy, labor and after delivery is one of the most important aspects of nursing care. If we take each stage as an example to demonstrate nursing recording for each of head nurse and nurse, the nursing recording should be as follows:

Nursing recording during pregnancy:

1. Baseline information about the mother:

Blood pressure  
Weight  
Urinalysis and urine test for albumin  
Urine test for sugar  
Duration of pregnancy  
Uterine fundus level  
Position of the fetus  
Presentation of the fetus  
Fetal pulse  
Engagement  
Edema  
Reflexes  
Appointment for next visit

2. Listing of the minor health problems during pregnancy.

The head nurse concludes these problems from the baseline information gathered previously. These problems usually include any of the following:

- Headache
- Visual disturbances (dizziness, blurring of vision)
- Nausea and drowsiness
- Vomiting
- Constipation
- Frequency of urination
- Back pain
- Vaginal discharge
- Varicose veins

3. After the head nurse determines the health problems, she determines the nursing care needed as follows:

Nursing problems	Necessary care
1. Varicose veins in the legs	<ul style="list-style-type: none"> <li>*Explain how to wear elastic stockings</li> <li>*Avoid prolonged standing</li> <li>*Explain the effect of pregnancy hormones on varicose veins</li> </ul>
2. Weight 100 kg	<ul style="list-style-type: none"> <li>*Explain diet plan and other alternatives</li> </ul>
3. Heartburn and morning sickness	<ul style="list-style-type: none"> <li>*Explain that this occurs due to the effect of pregnancy hormones and not because of disease.</li> <li>*Avoid <math>\text{NaHCO}_3</math> since it does not help digestion and helps collection of gases that prevent vit.B absorption.</li> <li>*Small meals every 2 hours.</li> <li>*Eating bread and jam before getting up.</li> </ul>

4. The progress in the pregnant woman's condition and the method used by the nurse to record it.

Problem #1 Varicose veins.

- a) The nurse records the symptoms:
  - Leg pains, especially on standing, and dizziness
- b) The signs observed by the nurse:
  - The mother has bandage around her leg due to leg swelling.

c) Nursing care done by the nurse:

- Explain to the mother that 10% of pregnant women have varicose veins and this is not due to the baby's weight pressure on the pelvic vessels but it is due to the dilating effect of progesterone on blood vessels.
- Explain to the mother how to wear elastic stockings by raising her leg 90° for a few minutes before wearing the stockings in order to drain blood from the dilated veins and wear them at night. Tell her to never wear tight elastic bands to hold the stockings and advise the pregnant woman not to stand for long time.

Problem # 2 The mother weighs more than 100 kg.

- a) Symptoms: easy fatigue, limitation of movements, and heaviness
- b) Signs: sweating, shortness of breath, and low blood pressure
- c) Evaluation of the condition and outlining of nursing care:

Patient's weight

Diet plan to decrease weight

Explanation of the importance of weight gain control during pregnancy

Nursing care plan that the pregnant woman should follow until her next visit

Diet to lose weight:

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Breakfast: milk without sugar - an orange - 300g bread - teaspoon of butter - 1 egg

Alternative: 2 toast, - 2 spoons of beans - 1 lemon - 1 cup of milk

---

Lunch: 120 g vegetable soup - piece of meat

Alternative: legumes - vegetables - teaspoon butter - fruits

---

Dinner: fish or an egg with toast - teaspoon of butter - fruits

Alternative: 2 tablespoon beans - cheese - toast - 1 cup of milk

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### Practice Questions

1. Explain how a nurse can improve the quality of nursing care through nursing recording.
2. List the steps that a nurse follows for recording the nursing care delivered to her patients.
3. A pregnant woman visited the clinic:
  - a) What baseline information should the nurse obtain from the patient?
  - b) Give examples on the health problems that you may suspect from the primary information you have gathered.

To the Learner: Turn the page to check your answers.

## Answers to Practice Questions

1. The nurse can greatly improve nursing care by precisely recording all the information and data concerning the patient's condition, needs and treatment, so that this information can be retrieved whenever necessary.
2. The steps that a nurse follows for recording nursing care delivered to a patient are:
  - a) Collect baseline information.
  - b) Identify the health, psychological and social problems of the patient.
  - c) Determine the direct nursing care for each problem.
  - d) Follow up the patient's condition through the nurse's notes.
  - e) Write a discharge summary.
3. a) The primary data include:
  - Blood pressure
  - Weight
  - Urinalysis and urine test for albumin
  - Urine test for sugar
  - Duration of pregnancy
  - Uterine fundus level
  - Presentation of the fetus
  - Fetal pulse
  - Engagement
  - Edema
  - Reflexes
  - Appointment for next visit
- b) Examples of the health problems:
  - Headache
  - Nausea and drowsiness
  - Constipation
  - Backpain
  - Varicose veins
  - Visual disturbances
  - Vomiting
  - Frequency of urination
  - Vaginal discharge

**To the Learner:** If you missed any of the answers to the questions, go back to the information section and study it again. When all of your answers are correct, go to section 5 on the next page.

## 5. Management of Equipment in Health Units

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### Learning Objectives:

At the end of this information section, you will be able to:

1. explain why it is important for the head nurse to be familiar with the instructions concerning the stock and storage of inventory;
  2. identify the method used to assess the health unit's needs for equipment and instruments;
  3. determine the methods for obtaining needed equipment and supplies;
  4. identify the types of inventories;
  5. state the nurse's and head nurse's role in the maintenance of equipment and instruments; and
  6. explain the reason for having an inventory of the articles and equipment present in the health unit.
- 

It is important that the head nurse be familiar with the instructions concerning stock and storage of inventory so that she will be able to:

1. determine the health unit needs for equipment, instruments and supplies.
2. obtain needed instruments and equipment.
3. receive and store different articles.
4. dispense different articles to different departments.
5. order necessary maintenance.
6. inspect inventories.
7. dispose of old and used articles.

## 1. Determining the unit needs for equipment and instruments

The director of the health unit estimates at the beginning of the fiscal year the unit needs for equipment, articles, instruments and supplies. The heads of the different departments, including the head nurse, help the director in that matter. The head nurse lists the articles that are needed to carry out the nursing activities in the unit. The list should include the quantities of the articles needed, especially those items not available in suitable quantities.

For the estimation of these quantities to be realistic, the consumption rates in previous years could be used as a guide. An annual percentage increase (5-10%) is added to the estimated figures, if there is actual consumption increase. These orders are sent to the medical supplies department at the beginning of each fiscal year.

## 2. Obtaining needed equipment, instruments and other supplies

### a) Buying supplies through offers:

After determining the needed articles, the stock clerk makes a list of all the articles needed and distributes this list to the different suppliers. The suppliers are asked to turn in their detailed offers covering each article by a certain time. These offers should include a detailed description of each article (e.g. size, weight, color, price and time of delivery). After the deadline for receiving the offers is over, a committee, usually including the head nurse or her representative, decides on the best offer taking into consideration the price and the quality of the article. A written form should be signed by the members of the committee and sent to the legal department to sign the contract with the supplier.

Item	Unit	Number requested	Suppliers and price in \$			Note
			Company A	Company B	Company C	
Autoclave		2	200	150	300	Company A offer is accepted

Figure #1

### b) Ordering supplies through a catalogue:

Sometimes certain items have to be ordered from companies or factories that are far away or even outside of the country. In this case,

a catalogue is used to determine the kind of articles needed according to their numbers in the catalogue. A list containing all the items needed is sent to the different suppliers with a letter requesting them to send their offer before the indicated deadline. The offers should contain the price of each item and for how long is the price valid. The same steps followed in the local offers are applied in this case. One main disadvantage of ordering through a catalogue is that the buyer cannot see the merchandise.

### 3. Receiving and storing of articles:

Whenever the requested articles arrive at the unit, the director of the unit appoints a committee to receive these articles. The committee should include a representative from the nursing department. The committee's duties are to open the boxes and make sure that the articles meet the qualifications and specifications stated in the offer as well as to inspect for any missing or broken parts.

A written form is to be signed by the committee members after their approval of the articles. The stock clerk stores these articles in their appropriate places and fills out the forms concerning the numbers of units and the date of arrival.

### 4. Dispensing the different articles to the different departments: (Personal and secondary custody)

The stock clerk dispenses and distributes the articles to the different departments according to their needs. A request form is to be signed by the head of the department and approved by the director in order to release the required articles. Once these articles are released, they are under the custody and responsibility of personnel working in the department, i.e., they become a secondary custody in the department. Usually the nurse is the one who is responsible for these articles. However, all personnel are also responsible for taking care and maintaining this equipment and instruments.

Personal custody occurs when the head nurse or a nurse signs for a piece of equipment to use in her work. The person who signed for that piece of equipment is responsible for it. The secondary and personal custody causes the nurses to be uncomfortable. The nurses usually complain about the custody of inventory since they may have to pay for them in case of loss or damage. The custody of these articles is not a nursing activity and it wastes the nurse's time. Custody of equipment and supplies should be handled by non-nursing personnel.

### 5. Maintenance:

Equipment and instruments regularly need maintenance. The nurses are responsible for cleaning, storing and organizing these articles in the different departments. It is the nurse's responsibility to report any damage to these articles. The head nurse is responsible for supervising and training the nurses on how to use, clean, and store the equipment and instruments as well as to report any damage or loss.

#### 6. Inventory inspection:

Checking inventory of all the equipment and instruments present in the unit should be performed at least once a year before the end of the fiscal year.

A special committee is formed to carry out the inventory of all the items in the unit and compare their record with what is actually present in the storage rooms. The reason for carrying out an inventory inspection is to assure the safety of storage as well as to find out if there is any damaged or missing equipment. The different articles should be stored and protected in a way that they are easily identifiable. They also should be stored away from humidity, heat and theft.

#### 7. Disposing:

Every year the stock clerk makes a list of all the articles that need to be disposed of. A committee is formed to decide what needs to be disposed of due to damage or unsuitability for usage. It is important to mention the head nurse's role is to report to the responsible persons about the articles that need to be disposed to prevent their accumulation in the different departments. These unused articles could be a source of insects and rodents which in turn have a bad health effect on patients as well as on personnel health.

### Practice Questions

1. Explain why the head nurse must be familiar with the instructions concerning stock and inventory of storage.
2. What is the head nurse's role in determining the unit's needs of equipment and instruments?
3. Identify the methods used for obtaining supplies and equipment.
4. List the types of inventory custody in the health units.
5. State the problems that the nurses have from keeping custody of inventories.
6. What is the nurse's and head nurse's role in maintaining equipment and instruments?
7. What is the purpose of having a yearly inventory inspection?
8. What is the head nurse's role in disposing of old articles?

To the Learner: Turn the page to check your answers.

## Answers to Practice Questions

1. It is important that the head nurse be familiar with the instructions concerning stock inventory and storage so that she can be able to:
  - a) determine the health units needs for equipment and instruments.
  - b) obtain needed instruments and equipment.
  - c) receive and store different articles.
  - d) dispense different articles to different departments.
  - e) order necessary maintenance.
  - f) inspect inventories.
  - g) dispose of old and used articles.
2. The head nurse helps the director of the health unit to estimate at the beginning of the fiscal year the unit needs for equipment, supplies, articles and instruments. The head nurse lists the articles that are needed to carry out the nursing activities in the unit. For the estimation of these quantities to be realistic, the consumption rates in previous years could be used as a guide. An annual % increase (5-10%) is added to the estimated figures if there is a consumption increase.
3. Methods used to obtain equipment, instruments and other supplies are:
  - a) buying supplies through offers.
  - b) ordering supplies through a catalogue.
4. The types of custodies are:
  - a) Personal custody
  - b) Secondary custody.
5. The secondary and personal custodies cause the nurses to be uncomfortable and worried because they may have to pay for any lost items in their custody.
6. The nurses are responsible for cleaning, storing and organizing the equipment and instruments in the different departments. The head nurse is responsible for supervising and training the nurses on how to use, clean, store the equipment and instruments as well as report any damage or loss.
7. The reason for carrying out an inventory inspection is to assure the safety of storage as well as to find out if there is any damaged or missing equipment.
8. The head nurse should report to the responsible persons about the items that need to be disposed of in order to prevent their

accumulation in the different departments. These unused items could be a source of insects and rodents which in turn have a bad health effect on patients as well as personnel.

**To the Learner:** If you missed any of the answers to the questions, go back to the information section and study it again. When all of your answers are correct, go to section 6 on the next page.

## 6. Organization and Management of Paperwork in Health Clinics

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### Learning Objectives:

At the end of this information section, you will be able to:

1. determine the paperwork that is included in each of the activities that take place in the health unit;
  2. write a letter to refer a patient to another health unit;
  3. state the importance of having a special system for keeping records and files;
  4. state the characteristics of a good filing system;
  5. identify the four methods used in filing;
  6. explain the reason for arranging and indexing the filing system; and
  7. give an example on how to make an index for a health unit filing system and give the best place for keeping and storing files.
- 

Paperwork is all the correspondence and printed matter that are delivered to or sent by the health unit concerning any of its activities. Paperwork is an important part of any unit's or hospital's activities. It supports and organizes the technical work of the health unit. All personnel, administrators, doctors, nurses, social workers, clerks, etc., each in his speciality, does his share of this paperwork.

Following is a list of the activities performed in the health unit with the paperwork accompanying each activity and the persons responsible for carrying it out.

<u>Activity</u>	<u>Paperwork</u>	<u>Persons responsible</u>
<u>1. Correspondance</u>		
Patients problems	letters concerning the patient	social worker
Administrative letters	in and out letters	clinic clerk
<u>2. Health care</u>		
Follow-up patients	health records	nurse
Examination and diagnosis	clinical record	physician
Treatment	treatment record	physician/nurse
Admission	inpatient record	physician/nurse
Vaccination	vaccination record	nurse
Maternal care	new pregnant women record	nurse
Child care	child health card	nurse
Statistics and reports	statistics and reports forms	clerk/physicians
Health education	pamphlets	social worker
<u>3. Financial and management</u>		
Time records	time cards records	clerk
Personnel problems and matters	employees files	clerk
Requests	request forms	nurse/clerk
Stock	stocks records	clerk

#### How to write a referral letter:

Whenever a patient is transferred or referred from one health unit or hospital to another, a letter of referral should always accompany the patient. The letter should contain information that helps the attending physician to have a good idea about the patient's medical history, previous medication, and condition. The following is an example of a referral letter:

Maternal and Child Care Center 20 Gomrok street, Gomrok, Alexandria Tel:	Letter no: Date: enclosures:
Subject: referring a patient	
Address and title	Patient Name: Alia Mohamed 22 years
Dear Sir:	
Patient name	
Patient complaints	
Primary diagnosis	
Treatment received	
Investigations done at the unit	
Request: Please admit the patient for treatment.	
Thanks,	
Name	
Title	

Figure #2

### The system for keeping records and files and its importance.

Sometimes it is hard to find important correspondence or needed information about patients because of the overcrowding of offices by correspondence and patients cards. When the problem of having too many papers becomes severe, they might be stored in the hallways or put in unlabeled files. Because of that, it is very important to have a special filing system that will make it easy to find information or documents quickly.

#### The characteristics of a good filing system are:

1. It should provide the space to keep all kinds of paper forms used routinely in health unit in order.
2. It should be simple enough that personnel can use it.
3. It should be easy to find the documents whenever they are needed.

#### Methods of indexing the files:

The following methods can be used:

- A. According to the alphabetical order
- B. According to the subject
- C. According to the number system
- D. According to geographical location

It is possible to use more than one method at the same time.

A. According to the alphabetical

Use the first letter of the patient's name.  
 This system is used when there are too many papers concerning similar subjects. It is the most suitable for personnel files.

B. According to subject:

This system is most suitable for general purposes especially in small health units. This system requires having a list of the documents present under each subject. Examples of these lists are:

a) Correspondance

Correspondance concerning the patients  
 Correspondance from the central office  
 Any other correspondance

b) Financial matters

Request forms  
 Bills  
 Inventory forms

C. According to the number system:

Every individual is assigned a number that is kept in his file or card. This system is used for patients and follow up cases.

D. According to geographical distribution:

A file is made for every district or village. The file should contain information regarding the names of district representatives, bus time tables, market days, etc. This is very useful in health units operating in villages and rural areas.

## File Index

Filing might not be sufficient enough to serve the purpose it is meant for, that is, finding the documents quickly and easily when they are needed. The files may be placed in the wrong place because an index system is not used.

A filing index shows the title and number of the file or record that contains certain information. Following is an example of an index in an office room in a health unit:

Office Index	
Documents and Information	Place
Administrative letters	General correspondance-upper shelf
Request forms	Right drawer of desk
Clinical records	Out-patient clinics box
Correspondance	Files, upper shelf
Discharge forms	Ward table
Bills	Closet
Vaccination cards	Out-patient clinic
Monthly reports	Files, second shelf
Stocks files	Storage closet
T.B. cards	Box in the out-patient
Information about the village	According to the name-3rd shelf

The best place to store and keep the records is the place where they are used. For example, the laboratory records should be kept in the lab, inventory records should be kept in the storage room, etc. Wherever these records are kept, they should always have a consistent and easy to locate place on a shelf or in a closet. Whenever the files or the records are not needed any longer, they should be sent to the medical record department for filing according to the rules of the unit.

## Practice Questions

1. List the paperwork included in the following activities and the personnel responsible for carrying it out.
  - a) Prenatal care
  - b) Statistics and reports
  - c) Requests
  - d) Neonatal care
  - e) Follow-up patients
2. Write the important points that should be included in a referral letter concerning a patient's condition.
3. What is the importance of having a particular system for filing records?
4. What are the characteristics of a good filing system?
5. Following are four phrases describing the four methods for filing. Give the name of the method that corresponds with each phrase.
  - a) Filing according to the information concerning each village or district
  - b) Filing according to the subject
  - c) Filing according to the first letter of the employee's or the patient's name
  - d) Filing according to the numbers assigned to the patients and individuals.
6. What is the purpose of having an index for the files?
7. Complete the following office index by giving the right place for keeping the following documents and information:
  - a) Patients' discharge file
  - b) Vaccination cards
  - c) Administration letters

**To the Learner:** Turn the page to check your answers.

## Answers to Practice Questions

1. 

a) New and follow-up pregnant woman chart	nurse
b) Statistics and reports forms	clerk/physician
c) Child health card	nurse
d) Letters concerning patients	social worker
e) Request forms	clerk/nurse
f) Records	nurse
2. Name of the patient - Address - Patient complaints - preliminary diagnosis - Previous medications - lab tests.
3. It is important to have a special filing system to facilitate finding documents or data whenever they are needed.
4. 

a) It should provide the space for keeping all kinds of paper forms used routinely in health unit in order.
b) It should be simple enough that the personnel can use it.
c) It should be easy to find the documents whenever they are needed.
5. 

a) According to geographical distribution
b) According to subject
c) According to alphabetical order
d) According to numbers
6. The index tells you what files have been made and where they are located.
7. 

a) Discharge cards	ward table
b) Vaccination cards	out-patient clinic
c) Administration letters	general correspondence-upper shelf

**To the Learner:** If you missed any answers to the questions, go back to the information section and study it again. When all of your answers are correct, you have finished the information sections of this learning module. Briefly study the sections again. Then take the Post-test on the next page.

## Post-Test

**To the Learner:** This test will tell you how much you have learned from this self-instructional module. After taking the test, check your answers on the page following the test. Be sure to use a separate sheet of paper for recording your answers.

1. State the eight important benefits of records and reports.
2. List the characteristics of good reporting and recording.
3. List the types of reports used by the nursing staff in the health units.
4. List the items that the head nurse includes in her daily report to the director of the health unit.
5. List the information that should be included on the daily shift report.
6. State the points that should be included in the accident and incident report.
7. State the points that should be included in the administrative report.
8. List the seven types of records used in nursing units.
9. Following is a list of sentences that describe the different kinds of records used in health units. Give the name of the record that corresponds with each sentence.
  - a. This record includes the name of the patient as well as the nursing staff responsible for providing nursing care for this patient and the duties assigned to each nurse.
  - b. This is a record of all the instruments, furniture, and equipment. The record also includes the quantity, condition, and specifications of the listed articles.
  - c. This document indicates the type of health care delivered to the patient. It also includes all the information concerning the patient since his first admission to the unit.
  - d. This record is prepared weekly or daily and includes the plan for nursing coverage for the health unit over a 24-hour period.
  - e. This record includes the observations of the patient's health condition as well as the nursing care given to him.
  - f. This record is used to evaluate personnel performance yearly or every six months.

10. Give two purposes for using each of the following records:
  - a. patient record
  - b. nurse's notes
  - c. personnel performance appraisal
  - d. duty roster
  - e. inventory record
11. Explain the nurse's and the head nurse's responsibilities for keeping patients' records.
12. Explain how a nurse can improve the quality of nursing care through nursing recording.
13. List the steps that a nurse follows for recording the nursing care delivered to her patients.
14. A pregnant woman visits the health unit.
  - a. What baseline information should the nurse obtain from the patient?
  - b. Give examples of the health problems that you may suspect from the primary information you have gathered.
15. Explain why the head nurse must be familiar with the instructions concerning the stock and storage of inventory.
16. What is the head nurse's role in determining the unit's needs for equipment and instruments?
17. Identify the methods used for obtaining supplies and equipment.
18. List the types of inventory custody present in the health unit.
19. State the problems that the nurses have from keeping custody of inventories.
20. What is the nurse's role in maintaining equipment and instruments?
21. What is the purpose of having a yearly inventory inspection?
22. What is the head nurse's role in disposing of old articles?
23. List the paperwork included in the following activities and the personnel responsible for completing it:
  - a. pre-natal care
  - b. statistics and reports
  - c. requests
  - d. neo-natal care
  - e. follow-up patients

24. Write the important points that should be included in a referral letter concerning the patient's condition.
25. What is the importance of having a particular system for filing records?
26. What are the characteristics of a good filing system?
27. Following are four phrases which describe the four methods for filing. Give the name of the method that corresponds with each phrase.
  - a. filing according to the information concerning each village or district
  - b. filing according to the subject
  - c. filing according to the first letter of the employee's or the patient's name
  - d. filing according to the numbers assigned to the patients and individuals
28. What is the purpose of having an index for files?
29. Complete the following office index by giving the right place for keeping the following documents and information:
  - a. patients' discharge file
  - b. vaccination cards
  - c. administration letters

## Answers to Test

1.
  - a) They provide qualitative as well as quantitative records of the unit and nursing activities that can be referred to whenever necessary.
  - b) They are one of the means that can be used to evaluate the personnel performance.
  - c) They are a method of communication between the employees and their superiors.
  - d) They provide indicators that help when planning for health and nursing services.
  - e) They provide indicators that help in organizing educational and training programs.
  - f) They are one of the tools used to determine the communities' health status problems, and the prevalent diseases and their treatments.
  - g) They provide a tool for comparative studies in the fields of nursing and public health.
  - h) They are dependable documents used in legal cases to protect health institutions and personnel.
  
2. The characteristics of a good report and record are:
  - a) accurate, clear and honest documentation.
  - b) complete, correct and objective information chronologically organized.
  - c) punctuality when reporting important information, accidents, or disasters.
  - d) The report should be signed and dated including the time, if necessary.
  
3. The types of reports are:
  - a) Daily report
  - b) Shift report
  - c) Patient census report
  - d) Work problems and follow-up on suggested solutions report
  - e) Accident and incident report
  - f) Patient complaints report
  - g) Administrative report
  
4. The head nurse should include the following data in her report to the director of the health clinic:
  - a) The general condition of the unit.
  - b) The patient and the consumer census.
  - c) The patients who have changes in their conditions or who developed complications and the procedures done for them.

- d) Admission cases, discharges, transfers, and deaths.
  - e) Critical cases during the previous evening and the night shift.
  - f) Patients' complaints.
5. The shift report includes the following:
- a) Critical cases and nursing care provided.
  - b) Newly admitted cases.
  - c) The administrative part of the report which includes the number of nurses on the shift and the absenteeism.
6. Accident and incident reports should include:
- a) Name of the patient and diagnosis
  - b) Date of admission or visit
  - c) The time when the incident was noticed and the time it was reported
  - d) What was done to prevent the incident
  - e) Explanation of the circumstances under which this incident occurred
  - f) What steps were taken to correct the mistake
  - g) The date and signature of the reporter
  - h) The head nurse's suggestions to prevent the recurrence of this mistake
7. The administrative report includes the following:
- a) Brief summary about the unit activities, nursing personnel, number of working hours, shifts, statistics concerning number of deliveries, admitted and discharged cases and number of deaths.
  - b) The available resources such as instruments, equipment and maintenance facilities.
  - c) The obstacles that affect the nursing care in relation to manpower, environment, equipment and instruments.
  - d) The reasons for changing work routines, personnel, or resources and the results of these changes.
8. The seven records in nursing units are:
- a) Patient records
  - b) Nurse's notes
  - c) Nursing work assignment sheets
  - d) Duty roster
  - e) Inventory record
  - f) Time tables
  - g) Personnel performance appraisal
9. a) Nursing staff work assignment sheet
- b) Inventory record
  - c) Patient record
  - d) Duty roster

- e) Nurse's notes
  - f) Personnel performance appraisal
10. a) Purpose of Patient record:  
 Helps reach a diagnosis and treatment.  
 Records the services provided to the patient.
- b) Purpose of Nurse's notes:  
 To have a standardized record for writing the nurse's notes that is agreed upon by all personnel working in the clinic. This will make it easy to transfer patient care responsibilities from one nurse to another during the different working hours.  
 To facilitate fast review of the patient's condition as well as the nursing care provided.
- c) Purpose of Personnel performance appraisal:  
 To provide baselines for promoting or rewarding personnel.  
 To serve as an incentive for professional progress.
- d) Purpose of Nursing staff work assignment sheets:  
 To inform the nursing staff about their daily duties in writing.  
 To list the nurses responsible for each patient.
- e) Purpose of Inventory records:  
 To supply the head nurse with information regarding missing instruments and broken or old instruments that need disposal.  
 To be able to return any excess supplies to the right place.
- f) Purpose of Duty rosters:  
 To show the nursing coverage of the unit over a 24-hour period.  
 To keep a daily absentee record of the nursing staff.
11. a) The nurse's responsibilities towards the patients records are:  
 1) organizing the new patients records and seeing that it contains the necessary documents and forms.  
 2) recording the vital signs and writing the nurse's observations.
- b) The head nurse's responsibilities towards keeping patients records are:  
 1) the records should be kept in a safe place.  
 2) the records should not be given to anyone except to the treating physician or in a case of scientific duties or transferring of a patient.  
 3) forms should never be removed from patient's files for any reasons.  
 4) the patient's relatives or friends are not allowed to see the patient's files except by written permission from the hospital or health unit director.  
 5) instructions and training should be given to new nurses on how to write complete and correct nursing notes.  
 6) before the patient's discharge, the head nurse should make sure

that the patient's record is complete and correctly organized before it is sent to the medical records department.

12. The nurse can greatly improve nursing care by precisely recording all the information and data concerning the patient's condition, needs and treatment, so that this information can be retrieved whenever necessary.
13. The steps that a nurse follows for recording nursing care delivered to a patient are:
  - a) Collect baseline information.
  - b) Identify the health, psychological and social problems of the patient.
  - c) Determine the direct nursing care for each problem.
  - d) Follow up the patient's condition through the nurse's notes.
  - e) Write a discharge summary.
14. a) The primary data include:
  - Blood pressure
  - Weight
  - Urinalysis and urine test for albumin
  - Urine test for sugar
  - Duration of pregnancy
  - Uterine fundus level
  - Presentation of the fetus
  - Fetal pulse
  - Engagement
  - Edema
  - Reflexes
  - Appointment for next visit
- b) Examples of the health problems:
  - Headache
  - Nausea and drowsiness
  - Constipation
  - Backpain
  - Varicose veins
  - Visual disturbances
  - Vomiting
  - Frequency of urination
  - Vaginal discharge
15. It is important that the head nurse be familiar with the instructions concerning stock inventory and storage so that she can be able to:
  - a) determine the health units needs for equipment and instruments.
  - b) obtain needed instruments and equipment.



- e) Request forms
  - f) Records
- clerk/nurse  
nurse
24. Name of the patient - Address - Patient complaints - preliminary diagnosis - Previous medications - lab tests.
  25. It is important to have a special filing system to facilitate finding documents or data whenever they are needed.
  26.
    - a) It should provide the space for keeping all kinds of paper forms used routinely in health unit in order.
    - b) It should be simple enough that the personnel can use it.
    - c) It should be easy to find the documents whenever they are needed.
  27.
    - a) According to geographical distribution
    - b) According to subject
    - c) According to alphabetical order
    - d) According to numbers
  28. The index tells you what files have been made and where they are located.
  29.
 

a) Discharge cards	ward table
b) Vaccination cards	out-patient clinic
c) Administration letters	general correspondence-upper shelf