Records and reports

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- Records –an effective health record shows the extent of the health problems, needs to provide other factors that affect individuals ,their ability to provide care & what the family believes .
- What has been done & what do be done now also can be shown in the records. It indicates the plan for future.

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- Purposes

1. Provide essential data
2. Data required for application of professional services for the improvement of family's health.
3. Tools of communication between the HW.
4. Shows the health problems of the family- standardized sheet or form.
5. indicates plan for future.
6. base line data for long term changes
7. provides the opportunity for evaluating the nursing situation in the family.

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- Principles of record writing.

Questions have to borne in the CHN mind while recording records

1. Does the record focus on family & community as the object Of care?
2. Does the record present the problem in, explicit & dynamic terms?
3. Are the goals explicitly defined?
4. Is the action planned stated clearly?
5. Are the family responses to the problem & the nursing action taken clearly identifiable?

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CHN follows certain principles in record writing.

1.Develop own method of expression.

2. Written clearly, appropriately & legibly.

3. Contain facts based on observation, conversation &action.

4. neat, complete & uniform.

5. Careful handling

6.Record systems are essential for efficiency & uniformity of services.

7. Brief & accurate.

8.Provide periodic summary to determine the progress & to make future plans.

9.Should be written immediately after an interview.

10. Records are confidential documents.

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- **Type of records**

1. Cumulative records or continuing records-total history of individual
2. Family records

Filling records-could be arranged

1. Alphabetically
2. Numerically
3. Geographically
4. Index cards.

Registers

Indication of the total volume of service & type of cases seen.

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- **Reports** – can be complied daily, weekly, monthly ,quarterly &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 &registers & so it is relevant for the nurses to maintain the records regarding their daily case load,service load &activities.

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- **Purpose of writing reports**

1.To shoe the kind & quantity of service rendered over a specific period.

2. To show the progress in reaching goals.

3. As an aid in studying health conditions.

4.As an aid in planning.

5. To interpret the services to the public and to other interested agencies.