The reaction to any kind of loss usually begins with a period of grief, followed by mourning. Grief may trigger such emotional reactions as helplessness, hopelessness, sadness, guilt, despair, or anger. Mourning usually progresses from denial to a developing awareness and idealization of the lost object. The final resolution takes place when the individual reconciles himself and his loss.

A nurse's support can help a patient maintain his self-image through mourning and denial, no matter what that loss means. Elderly people are particularly vulnerable to this type of loss since they, more often than younger people, are forced to give up these symbols of security and stability.

An elderly woman who refuses to eat her meals at a nursing home may be suffering the pangs of loss. If no one intervenes, she will lose both weight and strength.

You can discover part of the reason of your patient's seeming stubbornness in such a situation, as I did when I talked with the nursing home patient just mentioned.

"At home, I ate a light meal whenever I was ready," the woman told me petulantly. "I just don't like sticking to a schedule."

The problem, though, was not simply one of a mealtime schedule. Instead, perhaps subconsciously, this woman was reacting to the loss of her home, her independence.

By encouraging her to discuss her routine at home, I devised a plan to allow her to exercise more independence in her daily schedule.

Another type of loss is developmental loss, a normal and ongoing process, but nonetheless a loss. The cessation of the menses at menopause, the gradually declining sex drive in the middle years and the memory impairment of ageing are all examples of this type of loss.

No matter how often a patient insists "It doesn't matter", loss can have a tremendous effect on his behaviour. So, be alert for every kind of loss, even those which may seem insignificant to you.

Reference List Aid

Before you do your first psychological assessment, study the accompanying reference list. By relying on non-judgemental observation, attentive listening, and open-ended statements, you can get the information you need...while at the same time creating an atmosphere of acceptance and trust. Note your findings in the Kardex and nursing care plan, as well as on the patient's chart.

Psychological assessment needn't be limited to hospitalized patients, however. The techniques can be used whenever you work with a patient, even during a short, clinic, office, or home visit. By identifying the reasons for a patient's attitude towards treatment, toward you, and toward himself, you can effectively eliminate many of his fears and frustrations. And, equally important, you can reduce the frustrations of your own job.

Courtesy : *Nursing-77*

Importance of the Nurses' Record

Maintenance of Nurses' Records, which are a part and parcel of the Patient Medical Records, has not so far been given the importance it deserves and many of our hospitals have not been maintaining these records properly. During the last decade, some major hospitals and teaching institutions in our country have, however, introduced Nurses' Notes in the hospitals' medical record system, says GOVERDHAN DAS MOGLI, Medical Records Officer, Jawaharlal Institute of Post-graduate Medical Education and Research, Pondicherry.

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

The main purposes of the medical record are to :

1. Provide a means of communication between the physician and other 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 research 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 all 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, endeavours to provide the best possible care for the 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 welfare. It is this intimate and constant contact that gives her so vital a role in his care.

Major Sections

There are three major sections of the Patient Medical Record :

1. *Identification or Sociological Section :* This section covers administrative and personal data. The requisite information is obtained in the Admitting Office and is recorded on the following forms : (a) Admission Record, (b) Summary Sheet, (c) Patient's Index Card (d) Patient Register.

2. *Medical Section :* This section contains statements on the studies, observations conclusions and activities of the attending physician and the residents working under him and any physician who was consulted. This information is recorded under the following headings : Chief complaint, Present illness, Past illness, Family

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 notes, 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, Nurses' observation chart, Composite (T.P.R.) graphic chart, Intake and output (daily fluid balance chart), Chart for special cases (e.g. Diabetic chart).

Nurses' 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 contributions 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 legal 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 recording requires accuracy, promptnes in reporting developments and careful itemization of services performed in carrying out the doctor's orders (The orders of the doctor should be in writing. If an order is telephoned, the nurse should make 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 doctor's 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 be charted before it is done. The nurse who "closes" a chart at midnight, who guesses at a temperature and records it or deliberately makes a 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 nurses' notes are of immense value as evidence of medical treatment and nursing care.

The Nurses' Record serves four major purposes : 1. As a record of the patient's condition during the physician's absence. 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.

Nurses' 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 facilitates the doctor to note the up-to-date data.

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

Intake and Output Chart : Recording of intake and output should be done as indicated. At the end of 24 hours two red lines should be drawn and in between these lines, the total 24-hour intake and output should be recorded. Provision is also made, 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.

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 entry of relevant notes on current therapy, including insulin and diet. Graphic presentation can be made below of the sugar content of a patient's urine and statements can be given on acetones present, insulin dosage, blood sugar content, etc.

In brief, the Nurses' 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.

Other observations which contribute to the usefulness of the record are : (1) Identification of the patient and the treating doctor; (2) how admitted—by wheelchair, ambulance or ambulatory; (3) complete recording of condition of patient on admission and on discharge, noting any mark, bruise, burn, rash or irritation; (4) recording of admission temperature, pulse and respiration; (5) routine and special procedures; (6) medication, 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 Nurses' 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.