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CLINICAL NURSING RECORDS STUDY

FINAL REPORT

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Executive Summary
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Study assigned as part of the FY 84 AMEDD Study Program; examined inpatient nursing documentation issues, testing new documentation forms and concepts. The study purposes were twofold: assess AMEDD nursing documentation system to identify specific problem areas; develop forms and guidelines to address the problems. The study was conducted in four separate phases: 1) In-depth assessment of current AMEDD nursing documentation system used in fixed facilities; 2 - 4) development, implementation and assessment of tested elements. The investigators were also charged with recommending permanent regulatory changes for inpatient nursing documentation. The study phases were conducted over a three year period; working groups of Registered Nurses and advisors in various capacities were involved during Phase 2, developing tested elements based upon the needs assessment conducted in Phase 1. Proposed changes were field tested at four AMEDD facilities within CONUS.

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19. (CONT.)
FINDINGS: PHASE 1. Perceived problem areas of documentation included issues related to directions for clinical record use and specific DA nursing forms; the necessity of transcribing orders from one paper to another; the lack of a standardized discharge format; the lack of standardized specialty area flowsheets; the overall reduncancy and fragmentation of patient progress in the medical record. PHASE 2. Priorities set by working and advisory groups were directed toward revising rather than completely overhauling the current system. Efforts centered around physician order transcription; documentation redundancy and fragmentation; revision of nursing history, assessment and care plans; development of a standardized nursing discharge format; development of standardized educational program or guidelines to implement changes. Form development was completed; guidelines were written; test sites were selected; site project officers were identified. PHASE 3. Site specific implementation activities are chronicled in the report. With implementation, common issues to each site were discovered: misprinted forms, lack of forms; overprints; inability to use a yellow highlighter to discontinue orders. These issues are discussed in detail. PHASE 4. Assessment of implemented changes occurred in three ways: POC debriefings; JCAH and IG surveys of patient records; site personnel surveys. Findings are reported in detail, in aggregate and POC debriefings centered around suggested form and guideline revision. JCAH and IG surveys were conducted at three sites; in general, for all sites, while nursing histories and assessments received praise for those records completed during testing, issues surrounding identification and prioritizing nursing care problems and related nursing interventions were noted for all facilities. Site personnel survey results suggested revisions to forms and guidelines, identified major problems with separated physician order forms, favored integrated progress notes, approved revised history, assessment, and care plan formats, approved tested discharge summary, approved the opportunity to expand the use of therapeutic documentation care plans (TDs) to record patient response. The authors discuss relevant issues surrounding simultaneous implementation of multiple complex changes, and resulting impact of tested elements. Recommendations include: revision of tested nursing history, assessment, care plan and discharge summary forms; adoption of the use of TDs to record patient responses; adoption of the use of integrated progress notes for all disciplines; adoption of changes for physician order recopy; continued use of yellow highlighter to discontinue order on TDs; use of only one form for all physician orders; plans for world-wide dissemination of documentation changes.

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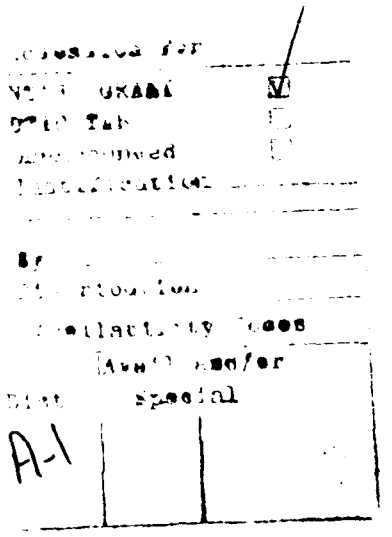

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The study effort spanned nearly five years; the writing of the technical report even longer. It is impossible to list all of the individuals and groups providing significant contributions. However special acknowledgments are in order for two groups: Army nursing personnel world-wide, and specifically, those at the four test sites. Input received from the "world" was read, distilled, prioritized. All study efforts were directed towards issues heard from the field. Without that contribution, we would never have begun. Those at the test sites, Fitzsimons Army Medical Center, and the Medical Department Activities at Forts Campbell, Jackson and Polk, led by their project officers, MAJ Timothy Williams, AN, MAJ MaryBeth Johnson, AN, MAJ Patricia Prather, AN, and LTC Sharleen Meyers, AN, respectively, are the true heros. Faced with arduous days, they willingly, eagerly, with infinite patience and true perseverance, worked with implementation challenges and provided investigators with the heart and soul of this study effort: their analysis, comments and suggestions.

COL (now retired) Marian J.I. Walls, AN was appointed as the study director. Her constant encouragement and guidance during the early days, as working group members, and investigators grappled with issues was instrumental in keeping us reality based.

All working group members and advisors listed in Appendix D were equally splendid, coming together as individuals, but working as a team to produce tested elements.

LTC (now retired) Terry R. Misener, AN, served not merely as co-investigator, but mentor, editor, friend. Any syntax errors or missed issues in this report are due to my own stubborn love of complex sentences, and not to his persistent red pen edits.

Finally, the other co-investigator, Mrs Patricia Twist, is a management analyst, not a nurse, but after this study she qualifies for the job. I suspect there were times when she felt she knew as much about nursing documentation as I did. She has worked hundreds of hours to assist in form design, site implementation, data analysis, not to mention the myriad of other details that go into producing a technical report. We traveled long distances, drank innumerable cans of diet soda, groaned at misprints, laughed at the bureaucracy. This report is as much a product of her diligent efforts as it is a chronicle of Army nursing personnel's desire to improve the system.

MRB

CLINICAL NURSING RECORDS STUDY

The study, assigned to Health Care Studies and Clinical Investigation Activity as part of the FY 1988 Army Medical Department (AMEDD) Study Program, expanded the emphasis to include all inpatient forms currently used in Army medical facilities. It evaluated system problems, developed, implemented and assessed tested changes based upon the initial needs assessment. The study was conducted over a four year period; implementation was conducted at four AMEDD hospitals within the continental United States (CONUS): Fitzsimons Army Medical Center, and the Medical Department Activities at Forts Campbell, Jackson and Polk.

The literature supports the necessity for nursing documentation. Medical, legal, and financial systems further support the need for concise, but detailed notation of the course of inpatient treatment and the patient's responses. Nursing documentation reflects nursing practice patterns based on planned nursing care, which, in turn, is predicated on identified problems and written goals. However, there is no universally accepted format for information.

This study was conducted in four phases. Phase One's evaluation of the present system was followed by the formation of working and advisory groups in Phase Two to address those issues identified in the first phase, set priorities and develop strategies for testing. Phase Three involved the intricacies of site testing. Phase Four evaluated tested elements and forms in several ways.

Content analysis of responses solicited by query letter from Army nursing personnel world-wide resulted in the following perceived documentation problem areas: issues related to directions for clinical record use and specific DA Forms (Nursing History/Nursing Assessment/Nursing Care Plans); the necessity of transcribing all orders appearing on physician order sheets to allow for annotation of required actions; the lack of a standardized discharge format and specialty area flowsheets; and the overall redundancy and fragmentation of patient progress documentation. Suggestions for change to address problem areas included revision of regulations governing documentation; form redesign; expansion of the use of therapeutic documentation care plans (TDs) to allow for the recording of patient responses; and the use of the Standard Form (SF) 509, Progress Notes, by all nursing personnel, in lieu of nursing notes, to facilitate multidisciplinary documentation. Suggestions for change were frequently accompanied by examples.

Working and advisory groups formed in Phase Two placed priorities on revision, rather than total overhaul, of the documentation system. Efforts centered around solving physician order transcription problems, decreasing redundancy and fragmentation, revising specific forms and developing a standardized educational program and guidelines to accompany implementation. Five revised and three new forms were tested. In addition to revised history, assessment and care plan formats, the use of a coding system on revised therapeutic documentation care plans (TDs) to indicate efficacy of intervention was also tested. Testing further included separation of medication and nonmedication orders on physician order sheets. Transcription of certain orders to revised TDs was eliminated because of the order sheet format. A standardized format was defined for a nursing discharge summary form; and the group chose to test the integrated note for all disciplines.

Phase Three's activities began in the summer of 1985. Project officers at the sites were identified; logistics were coordinated for form and educational material distribution; and testing was implemented. Forms were phased in at all sites over a one month period. Problems common to all sites were identified and resolved during the test period, but the greatest difficulty occurred when several forms arrived misprinted, leading to supply shortages and confusion for the users.

Phase Four's primary purpose was to assess all implemented changes. This was done in three ways: project officer debriefs; independent inspections by surveyors from the Joint Commission on Accreditation of Hospitals, the Health Services Command Inspector General's Office, and user questionnaires. Project officer comments centered around suggested form and guideline revision. JCAH and IG surveys reported that in general, while nursing histories and assessments received praise for those records completed during testing, issues surrounding identification and prioritizing nursing care problems and related nursing interventions were noted for all facilities. Site personnel survey results: suggested revisions to forms and guidelines; identified major problems with tested separate physician order sheets; favored integrated progress notes; approved of the revised history, assessment and care plan forms, in addition to the newly designed nursing discharge form; and approved the opportunity to record patient responses on the therapeutic documentation care plans (TDs).

The study demonstrated the enormity of instituting complex change within an equally complex system. Although integrated progress notes have been used by mental health providers for a number of years, this study also provided the first opportunity for its use by AMEDD providers of all disciplines and specialties. Although problems were encountered, the overwhelming majority (85.1%) of all users, including 63% of nonnursing respondents, were in favor of continuing use of the integrated note concept and expanding it to all providers.

Recommendations included revisions, with subsequent adoption, of tested nursing history, assessment, care plan and discharge summary forms; adoption of recording patient response on the therapeutic documentation forms; adoption of integrated progress use for all disciplines; adoption of changes for physician order recopy; continued use of yellow highlighter to discontinue orders on TDs; use of only one form for all physician orders; plans for world-wide dissemination of documentation changes.

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