Army Regulation 40–407

Medical Services

Nursing Records and Reports

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Washington, DC
15 August 1991

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SUMMARY of CHANGE

AR 40-407
Nursing Records and Reports

This revision adds the--

o Documentation of daily patient acuity classification on DA Form 4677 (Clinical Record--Therapeutic Documentation Care Plan (Non-Medication)) (chap 2).

o Documentation of the nursing discharge summary, DA Form 3888-3 (Medical Record--Nursing Discharge Summary) (chap 2).

o Use of DA Form 3950 (Flowsheet For Vital Signs and Other Parameters) (chap 3).

o Documentation of the patient care nursing process during the preoperative, intraoperative, and postoperative phases--DA Form 5179 (Medical Record--Preoperative/Postoperative Nursing Document) and DA Form 5179-1 (Medical Record--Intraoperative Document) (chap 5).

o Directions for Workload Management System for Nursing reports (chap 6).

o Guidelines for the internal use of DA Form 3761 (RCS MED 371) (chap 6).

This revision deletes the--

o Use of DA Form 4112 (Army Health Nursing Program--School Health Record). (DA Form 4112 was rescinded by DA Circular 310-81-7, 15 Jul 81.)

o Nursing audit; appropriate elements of the process are now incorporated in AR 40-68, appendix C.

o Quarterly Narrative Summary Report for Clinical Nurse Specialists.

o Use of DA Form 3888-1 (Medical Record--Nursing Assessment and Care Plan (Continuation)).

This revision changes the--

o Documentation process and forms for the nursing history assessment and care plan--DA Form 3888 (Medical Record--

Nursing History and Assessment) and DA Form 3888-2 (Medical Record--Nursing Care Plan) (chap 2).

o Content of Nursing Activities Report, DA Form 4798-R (Nursing Activities Report, RCS MED-369) (chap 6).

o Submission of the quarterly nurse's activities report to a monthly report--DA Form 4800-r (Nurse Practitioner/Clinical Nurse Specialist Monthly Activities Report, RCS MED-370) (chap 6).
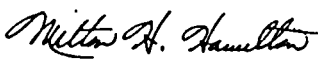
o Administrative data throughout.

Headquarters
Department of the Army
Washington, DC
15 August 1991

*Army Regulation 40–407

Effective 16 September 1991

Medical Services

Nursing Records and Reports

By Order of the Secretary of the Army:

GORDON R. SULLIVAN
General, United States Army
Chief of Staff

Official:

MILTON H. HAMILTON
Administrative Assistant to the
Secretary of the Army

History. This publication has been reorganized to make it compatible with the Army electronic publishing database. No content has been changed.
Summary. This revised regulation updates nursing records and reports; deletes nursing audit directions that are now incorporated in AR 40–68; and provides directions concerning Workload Management System for Nursing reports. It reflects requirements of current nursing principles and practices and the accreditation standards for healthcare organizations.
Applicability. This regulation applies to the active Army, The Army National Guard (ARNG) and the U.S. Army Reserve (USAR). This publication is applicable during mobilization.
Proponent and exception authority. Not applicable
Army management control process. This regulation is subject to the requirements of AR 11–2. Internal control review checklists have been published in DA Circular 11–89–1.
Supplementation. Supplementation of this regulation and establishment of command and local forms are prohibited unless prior approval is obtained from HQDA (DASG–CN), 5109 Leesburg Pike, Falls Church, VA 22041–3258.
Interim changes. Interim changes to this regulation are not official unless they are authenticated by the Administrative Assistant to the Secretary of the Army. Users will destroy interim changes on their expiration date unless sooner superseded or rescinded.

Suggested Improvements. The proponent agency of this regulation is the Office of The Surgeon General. Users are invited to send comments and suggested improvements on DA Form 2028 (Recommended Changes to Publications and Blank Forms) directly to HQDA (DASG–CN), 5109 Leesburg Pike, Falls Church, VA 22041–3258. Users within the U.S. Army Health Services Command will forward DA Form 2028 through Commander, U.S. Army Health Services Command, ATTN: HSCL–N, Fort Sam Houston, TX 78234–6000.

Distribution. Distribution of this publication is made in accordance with the requirements on DA Form 12–09–E, block 3433, intended for medical activities only at command levels B, C, D, and E for active Army. The Army National Guard, and the U.S. Army Reserve.

Contents (Listed by paragraph and page number)

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*This regulation supersedes AR 40–407, 1 November 1979 and rescinds DA Form 3888–1.

Unclassified

Contents—Continued

Chapter 1
Introduction

1–1. Purpose
This regulation prescribes the use and maintenance of nursing records, nursing reports, and certain parts of medical records by personnel of Army Medical Department (AMEDD) activities engaged in patient care and treatment.

1–2. References
Required and related publications, and prescribed and referenced forms are listed in appendix A.

1–3. Explanation of abbreviations
Abbreviations used in this regulation are explained in the glossary.

1–4. Responsibilities
   a. Chief nurses at the U.S. Army Health Services Command and 7th Medical Command. These nurses will forward the major Army command level nursing activities reports floppy disks to HQDA (DASG–HCM), ATTN: Program Manager, WMSN, 5109 Leesburg Pike, Falls Church, VA 22041–3258, not later than 45 days after the last day of the reporting period.

   b. The chief, department of nursing/nursing service. The chief will—

   (1) Complete and submit DA Form 4798–R (Nursing Activities Report (RCS MED–369)), in duplicate, under the detailed instructions given in this regulation. These reports are sent to the proper command headquarters listed below not later than the 10th of each month. One exception to this responsibility is noted in *d* below.

   (a) Commander, U.S. Army Health Services Command, ATTN: HSCL–N, Fort Sam Houston, TX 78234–6000.

   (b) Commander, Headquarters, 7th Medical Command, ATTN: AEMCL–N, APO New York 09102–3304.

   (c) HQDA (DASG–CN), Room 623, 5109 Leesburg Pike, Falls Church, VA 22041–3258.

   (2) Transfer the monthly summary data for the Workload Management System for Nursing (WMSN) to a floppy disk. (See FM 8–501.) Forward the diskette to the proper command headquarters listed below not later than 30 days after the last day of the reporting period.

   (a) Commander, U.S. Army Health Services Command, ATTN: HSRM–DR (Nurse Methods Analyst), Fort Sam Houston, TX 78234–6000.

   (b) Commander, Headquarters, 7th Medical Command, ATTN: Nurse Methods Consultant, APO New York 09102–3304.

   (c) Commander, 18th Medical Command, ATTN: Chief Nurse, APO San Francisco 96301.

   c. The chief, community health nursing section, at each medical center (MEDCEN) and medical activity (MEDDAC). The chief will complete and submit monthly the DA Form 3761 (Community Health Nursing Activities (RCS MED–371)) to the chief, preventive medicine at the medical treatment facility (MTF). Information copies will be furnished to the chief, department of nursing; deputy commander for clinical services; community health nurse staff officer, Health Services Command; and community health nursing consultant, HQDA (SGPS–PSP–D), 5109 Leesburg Pike, Falls Church, VA 22041–3258.

   d. Each nurse practitioner and clinical nurse specialist whose primary duty assignment is in an outpatient setting. These nurses will complete each month the DA Form 4800–R (Nurse Practitioner/Clinical Nurse Specialist Monthly Activities Report (RCS MED–370)) using the instructions in paragraph 6–3. Send the report to the chief of the department of nursing. Not later than 20 days after the last day of the reporting period, forward the completed report(s) to Commander, U.S. Army Health Services Command, ATTN: HSPA–A/Ambulatory Nurse Administrator, Fort Sam Houston, TX 78234–6000.

   e. Operating room (OR) and anesthesia personnel. These personnel complete entries in OR and anesthesia forms and records and include physicians, dentists, Army Nurse Corps (AN) officers, civilian registered nurses (RNs), operating room and/or anesthesia secretaries or typists, and others authorized locally. The chief, anesthesia and operative service has final responsibility for use and recording on OR and anesthesia documents.

   f. Physicians or dentists. The medical or dental officers and other authorized prescribers are responsible for prescribing the medical or dental plan of treatment in the form of written orders on DA Form 4256 (Clinical Record—Doctor's Orders).

   g. Clinical head nurses and community health nurses. The AN officer or civilian RN who acts as the clinical head nurse of a patient care unit or health activity is responsible for the accuracy and completeness of all entries made in nursing records and reports in inpatient treatment records (ITRs), health records (HRs), and outpatient treatment records (OTRs) by assigned nursing personnel and for ensuring compliance with all doctors' orders. (ITRs, OTRs, and HRs are those kept in the DA Form 3444 series (Alphabetical and Terminal Digit File for Treatment) folder.)

   h. Personnel responsible for entries. Personnel who will make entries in nursing records and reports include AN officers, civilian RNs, licensed practical nurses, enlisted nursing personnel, and others authorized locally. Each is individually responsible for notations.

1–5. Use and disposition of forms
Forms prescribed in this regulation will be used. Disposition of these forms and records will be in accordance with AR 25–400–2 unless otherwise specified.

Chapter 2
Permanent Clinical Forms

2–1. General
Initiation of a permanent ITR is an essential part of the inpatient admission procedure. A permanent HR for soldiers or an OTR for all other beneficiaries (DA Form 3444 series folder) is maintained for each outpatient seen in an Army MTF (AR 40–66). Authorized medical record forms for which nursing personnel are responsible or use frequently are described in this chapter.

2–2. Recording data
   a. All entries will be made with a pen, using reproducible permanent black or blue–black ink, except when specifically stated otherwise. Erasable ink and felt tip pens will not be used.

   b. The signature on clinical and/or medical records include the writer's first and last name with the individual's rank and title. For military personnel, give the rank and corps (for officers) or rank and military occupational specialty (MOS) (for enlisted personnel). Civilian personnel need to state their civilian grade and professional licensure as an RN or as a licensed practical nurse (LPN). A 91C who is licensed as an LPN should signify this by writing LPN after their MOS. See examples in figure 2–l.

Susan Jones, CPT, AN—Military nurse

James Brown, RN, GS–10—Civilian nurse

Barbara Smith, RN—Contract nurse

Thomas Allen, SPC, 91A—Military corpsman

Beth Foster, MSG, 91C, LPN—91C with LPN license

Michael Foley, SGT, 91C—Unlicensed 91C

John Fox, MSG, 91C, RN—91C with RN license

Figure 2-1. Examples of recording 91C licensed as LPN

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   c. To verify initials that are on medical records documents, DA Form 4700 (Medical Record—Supplemental Medical Data) with the typed name of each staff member, their payroll signature, and their

initials must be placed in each ITR. Initials must be legible and correspond to the individual's name (for example, Tim Scott is TS).

d. All dates will be written in day, month, year sequence; months will be stated by name and not by number (for example, 17 Jun 91).

2–3. Correcting errors
Erasures are prohibited. A line will be drawn through an incorrect entry and the initials of the person making the entry with reason for the change (for example, wrong patient) will be written above the lined–through entry. The correction information will then be re-corded following the lined–through entry.

2–4. DA Form 4256 (Clinical Record—Doctor's Orders)
a. Disposition and use. DA Form 4256 is a three–part carbonless form. The second and third copies can be used only once since they totally detach with the use of one perforated segment of the form.

(1) The original copy of the form (white copy) remains with the ITR and is used to communicate the orders to the nursing staff.

(2) The second copy (pink copy) is sent to the pharmacy. The pharmacy receives a copy of all orders to ensure proper surveillance of interactions that could occur between drugs and/or foods and other orders. The pharmacy copy is retained until the patient is discharged.

(3) The ward copy (yellow) is used according to local policy. It may be used as a medication or treatment reminder and will be discarded when no longer required. Entries must be legible on all three copies.

b. Preparation. Enter all patient identification as directed in AR 40–66. Addressograph plates should be used in each part marked "Patient Identification." The nursing unit, room number, and bed number should be completed.

c. Method of writing orders. The prescriber will record the date and time the order is written as indicated on the form. One or more orders may appear in each part of the form, but no more than one order may appear on a single line. Use of the entry "Routine Orders" (to imply a number of predetermined orders) is prohibited. A group of orders written at one time for the same patient requires one signature and the date and time entry for each order sheet. Overprinted standard orders must have any blanks completed and must be signed by the prescriber. Overprinted orders that the prescriber does not want implemented should be lined through and initialed by the physician initiating the standard orders. Orders should be numbered sequentially and unused portions of the form lined out if a new form is initiated.

d. Method of accounting for orders.

(1) Written orders will be accounted for in the far right column of the form in the "List Time Order Noted and Sign" column. The nurse (or clerk) who notes the orders will enclose the orders in a bracket, will list the date and time and sign his or her name to indicate that the orders have been transcribed to DA 4677 (Clinical Record—Therapeutic Documentation Care Plan (Non–Medication)) or DA Form 4678 (Clinical Record—Therapeutic Documentation Care Plan (Medications)). For a single order the initials of the nurse or clerk who notes and transcribes the order may be used in lieu of the person's signature.

(2) Single action orders need not be transcribed to the DA Form 4677 or DA Form 4678 if the order is noted by the RN. A single action order is a one–time order that is completed by the verifying nurse. It should require no further nursing activity once signed off including, if indicated, documentation of the efficacy of the inter-vention. In the right hand column of the form the RN will write "Done" with his or her signature and the date and time that the order was completed. Each single action order must be accounted for individually; brackets will not be used to sign off a group of single action or "STAT" orders. If the single action is not completed within the responsible RN's tour of duty, the order must be tran-scribed to the DA Form 4677 or DA Form 4678.

e. Method of discontinuing orders.

(1) To discontinue a medication or treatment, a stop order must be written and signed by the prescriber.

(2) Automatic stop orders (for example, antibiotics or controlled drugs) will be governed by local written policy.

(3) When an order is stopped, it is noted as described in *d* above. It must then be noted as discontinued on the corresponding DA Form 4677 or DA Form 4678 as described in paragraphs 2–8 and 2–9 below.

f. Verbal orders will be confined to emergency "STAT" orders only and accepted only by an RN. The RN accepting the order(s) must record the order(s) on the DA Form 42S6 followed by the notation "Verbal Order(s);" the physician's name; and the RN's name, rank, and title. The order(s) must be countersigned by the prescriber as soon as possible following the emergency.

g. Telephone orders will be held to the minimum and accepted only by an RN; they must be countersigned by the prescriber within 24 hours. The RN accepting the order(s) must record the order(s) on the DA 4256 followed by the notation "Telephone Order(s);" the physician's name; and the RN's name, rank, and title.

2–5. Documentation of the nursing process
a. Purposes.

(1) The purposes of the AMEDD nursing process documentation are to—

(a) Provide information for all patient care providers about the patient's clinical condition.

(b) Provide a basis for planning and assuring continuity of care.

(c) Provide a basis for evaluation of care.

(d) Establish accountability for care.

(e) Serve as a legal document.

(f) Provide information for research and education.

(g) Provide the information for calculating patient acuity.

(h) Record the quantifiable nursing activities for workload measurement.

(2) Nursing records complement each other. When the inpatient treatment record is reviewed, the documentation should reflect the nursing process beginning when the patient is admitted to the hospi-tal and continuing until the patient is discharged.

b. Forms. The following forms are used to document the compo-nents of the nursing process: Assessment, planning, implementing, and evaluation.

(1) DA Form 3888 (Medical Record—Nursing History and As-sessment). The assessment is the initial appraisal by an RN of a patient's status and healthcare needs.

(2) DA Form 3888–2 (Medical Record—Nursing Care Plan) is used in conjunction with the DA Form 3888, DA Form 4677, and DA Form 4678 to develop an individualized plan of care.

(3) DA Form 3888–3 (Medical Record—Nursing Discharge Summary) documents the patient's diet, medications, treatments, and follow–up care to be implemented upon discharge from the hospital.

(4) Standard Form 510 (Clinical Record—Nursing Notes) docu-ments the patient's status and the effects of nursing intervention.

2–6. DA Form 3888 (Medical Record—Nursing History and Assessment)
a. Purpose. DA Form 3888 documents a baseline nursing history and assessment on each patient. If completed at the time of admis-sion, it may serve as the admission nursing note. If not completed at admission, a nursing admission note must be written on the SF 510 in accordance with paragraph 2–l0c.

b. General. The nursing history and assessment will be com-pleted for each patient within 24 hours of admission. Although any of the nursing personnel may participate in data collection, the nursing assessment must be completed and documented by the RN. Overprints that serve as guides for the nursing history and assess-ment may be printed on the forms in accordance with the appropri-ate local or command policy. Overprints must facilitate completion of a form and not provide substitute information (AR 40–66). All forms are a permanent part of the patient's lTR.

c. Preparation. Enter all patient identification data as indicated on the forms.

d. Content. DA Form 3888. Data entered on this form represents

baseline health status information used by the nurse to plan care. The information may be obtained from the patient, other informed persons, and/or the patient's records.

(1) The front portion of the form, containing a brief, series of questions, provides a guideline for the interview.

(a) Date and time of admission with admitting diagnosis as specified by the physician, are recorded in the provided space.

(b) Response by the patient to the interview questions is recorded next to the questions in the area provided.

(c) Spaces are provided for the recording of information to assist in contacting the next of kin, or in their absence, another person designated as a point of contact for concerns arising as a result of the hospital episode (for example, support person, company commander, first sergeant, etc.).

(d) The person collecting the data is to sign his or her name, rank, and title and specify the informant from whom the data was obtained by name and relationship (for example, patient, Mrs. Jones or aunt, Mrs. Allen).

(e) A space is provided for the noting of the disposition of articles brought to the hospital. Initialing by the interviewer attests to where such items were consigned. It does not mean the interviewer was the one who actually placed the article(s) in the designated area.

(2) The reverse side of DA Form 3888 provides spaces for recording admission vital signs and for completing the nursing history and nursing assessment.

(a) Categories of assessment, with guidelines, are provided at the bottom of the page for assistance in making the nursing assessment. Data on the biophysical parameters for the listed items should be collected as appropriate for planning care.

(b) Admission vital sign data will be recorded in the spaces provided.

(c) DA Form 3888 must be completed by the RN on admission or within 24 hours of admission. The date and time is recorded on the DA Form 3888 with the signature of the RN who completed the nursing assessment. If the DA Form 3888 is completed at the time of admission, an admission note is not needed on the SF 510. An entry must be made on the SF 510 to refer to the DA Form 3888 for the admission note.

(d) The nursing assessment is reviewed and revised as additional data are collected and patient needs change. Updated nursing assessment should be documented on the SF 510.

(3) The RN may use multiple modalities to collect patient data from which a plan of care is developed. Regardless of what data is collected, and by whom, the professional nurse is ultimately responsible for the validity and reliability of the collected data.

2–7. DA Form 3888–2 (Medical Record—Nursing Care Plan)

a. Purpose. DA Form 3888–2 is used to document the identified nursing care problems with goals derived from the problems and discharge considerations including patient and family educational needs. Although all persons involved in the patient's care will contribute to the development of the care plan, the RN is responsible for its preparation. It is used by all nursing personnel caring for the patient. The nursing care plan is a permanent part of the patient's ITR.

b. Preparation. Enter all patient identification data as indicated on the form.

c. Content. The nursing care plan will reflect current nursing standards and measures which will facilitate the prescribed medical care and restore, maintain, and promote the patient's well being. It is used in conjunction with DA Form 4677 and DA Form 4678 that list the nursing actions and other prescribed orders related to implementing the doctor's orders and to achieving the specified goals.

(1) Record the date nursing diagnoses and/or patient problems are identified, the initials of the responsible RN, and the sequence number of the problem in the appropriate columns.

(2) Problems or nursing diagnoses are to be listed in the appropriate column. (See DA Pam 40–5.) Nursing diagnoses may be used in lieu of patient problems. Nursing diagnoses describe the patient's

actual or potential health problems. They represent clinical judgments made by the professional nurse and are conditions primarily resolved by nursing care interventions. Categories and diagnoses listed on the form are merely guides. As patient problems (or nursing diagnoses) are identified, they are recorded in the appropriate column and numbered in sequence. Problem statements are reviewed and revised by the RN to reflect the changing needs of the patient. For each identified problem and/or nursing diagnosis, nursing interventions stated as nursing orders must be written on the DA Form 4677 and/or DA Form 4678. (See DA Pam 40–5.) Nursing orders should be identified by the number of the relevant nursing diagnosis and/or patient problem.

(3) Expected outcomes (goals) based upon the problems listed in the preceding column on the forms will be specified. (See DA Pam 40–5.) Goals need to be stated as patient outcomes. Goals are the desired results of planned nursing interventions and should be mutually set with the patient and/or family. Based on the nursing assessment, they will be realistic, measurable, and consistent with the therapy prescribed by the responsible physician. When a problem no longer exists or the goal was accomplished or revised, the date the goal was accomplished or revised will be entered in the Date Accomplished column. Corresponding nursing orders on the therapeutic documentation care plans will then be discontinued and, if indicated, new orders should be written.

(4) In those instances when there are no individual patient care problems identified on admission, the professional nurse will document this on the care plan. For example, "patient care needs have been assessed and Standards of Care (cite the nursing diagnosis or patient care need; such as, postoperative care) have been implemented." Each patient's status will be reassessed at least every 24 hours. If there is no change, document that a periodic assessment was done and that the status remains unchanged. The reassessment of the patient should be a nursing order for those who have no identified problems specified on admission. The reassessment and subsequent findings may be documented directly on the care plan or in the nursing notes.

(5) For patients without any identified problems, Standards of Care with nursing orders documented on the DA Form 4677 and DA Form 4678 are the basis for the patient's planned nursing care.

(6) Discharge planning begins at admission with the assessment by the RN on DA Form 3888. Note the discharge considerations identified at admission and throughout hospitalization in the space provided on DA Form 3888–2.

2–8. DA Form 4677 (Clinical Record—Therapeutic Documentation Care Plan (Non–Medication))

a. Purpose. This form, printed on colored paper, is used for non–medication doctors' and nurses' orders and to document the patient's acuity category. Medical orders will be transcribed from DA Form 4256. Nursing orders, initiated by the professional nurse, and written on this form will be indicated by writing "NIO" for nursing initiated order and the nurse's initials in the Initials column. If the nursing orders on this form relate to identified nursing problems and/or nursing diagnoses, identify the number of the relevant nursing problem and/or diagnosis with the nursing order(s). Nursing orders that reflect standards of care may be written without a corresponding problem. Overprints of orders may be printed on the form per appropriate local or command policy.

b. Preparation. Enter all patient identification data as indicated on the form.

c. Content.

(1) Allergies. Specify the presence or absence of allergies. When known, indicate the specific allergen.

(2) Primary diagnosis. Enter the current diagnosis. Add other diagnoses if they significantly affect care to be given.

(3) Recurring actions.

(a) Order date. Enter the date that the current order was written.

(b) Initialing. The clerk or nurse who transcribes an order must initial the block specified on the form. If a ward clerk or a licensed practical nurse transcribes the order, an RN must initial in the lower portion of the box. The RN's initials indicate that the RN verified

the order on DA Form 4256 and is, therefore, accountable for its accuracy and its appropriateness from a nursing standpoint.

(c) Recurring actions, frequency, time. This section is used for actions that are scheduled and repetitive. The complete order, as originally written, must be transcribed to this section.

1. Hour. Specific times are listed vertically. Each space is for a separate time of action. Orders that are in effect throughout the shift and are not time–related or sensitive (for example, seizure precautions, intake and output, activity level, etc.) are indicated by designating the inclusive times for each shift; for example, 07–15, 15–23, 23–07. The abbreviations D, E, and N will not be used.

2. Date. The top row of spaces is used to indicate the date the action is accomplished.

3. Initialing. The responsible person will initial the block opposite each specific hour line for action and under the appropriate date column to verify compliance with the order.

4. Use of DA Form 4677 to document patient acuity. The WMSN acuity category is documented on this form. An entry should be made in the Recurring Actions/Frequency/Time column: "WMSN Category." Two lines are used. The WMSN acuity category is recorded on the first line under the appropriate date, and the initials of the RN who determined the acuity category are recorded on the second line in the block directly beneath the category.

5. Use of DA Form 4677 as a flowsheet. To decrease the necessity of writing nursing notes, DA Form 4677 may be used to document patient information requiring frequent recording and/or the patients' responses to medical orders and nursing interventions. Directions should be developed locally to describe how to word nursing orders and to use codes most effectively. All assessment or measurement components must be specified in the order. For example, check pedal pulses and right leg circumference every 4 hours. These findings are then recorded on the DA Form 4677. To record the patient's response(s) to interventions, a local policy specifying the coding of this information is required. For example, initials only indicate that the order has been completed; initials and "+" indicates that the nursing intervention and/or observation was satisfactory and/or within normal limits; initials and "O" indicates the results of the nursing intervention or observation were unsatisfactory, not observed or omitted, and requires further documentation on the SF 510. All unexpected responses or unfavorable patient outcomes require documentation on the SF 510 until an anticipated or normal finding is documented. The initials of the nursing personnel implementing the order should be recorded on the first line under the appropriate date and the required information or code data in the block directly under the initials. Unused portions of the form are to be lined out. The codes must be defined on the DA Form 4677.

6. Discontinued order. When an order is discontinued, a diagonal line is drawn across the remaining blocks. If it is a single line order, draw a horizontal line; write "DC/date/time/initials" above the line. For quick, visual recognition of a discontinued order, a yellow highlighter or accent pen which will not penetrate the paper or obliterate the writing may be used to line over the order and the remaining unused blocks.

d. Single Actions. If a single action order is not completed within the responsible RN's tour of duty, the order becomes a delayed order and is transcribed to the Single Actions column.

(1) *Order Date.* Same as in *c*(3)(*a*) above.

(2) *Initialing.* Same as in *b*(3)(*b*) above.

(3) *Single Actions.* The complete order, as originally written, must be transcribed to this column.

(4) *Date and Time to Be Done.* Enter the date and time, if known, the action is to be taken. Indicate "on call" if so ordered.

(5) *Completed order.* Complete the Date/Time/Initial block to show that the order was completed. If the order was not completed, do not initial. Place a circle in the Date/Time/Initial block and specify the reason in the nursing notes.

e. Pro re nata (PRN) actions. Use this when the time of an order is not predictable. Leave sufficient space on the DA Form 4677 to accommodate the expected frequency of the PRN action and the

patient's response per local policy and the direction provided in *c*(3)(*c*)5 above.

(1) *Order/Expir (expiration) Date.* Enter the date the current order is written in the top portion. If applicable, enter the expiration date in the bottom portion.

(2) *Initialing.* Same as in *c*(3)(*b*) above.

(3) *PRN Action, Frequency.* Indicate the action to be taken and its frequency.

(4) *Time/Date/Completed.* Each block indicates a separate action. The person completing the action enters the date, time, and initials at the time of completion.

f. Recopied orders.

(1) When space in the Date Completed column is filled, a double line is drawn across the entire page just below the last entry. Directly below the double line, or on a blank DA Form 4677, write "Recopied Orders." The upcoming dates are filled in, for each order still in effect, and the date of the original order is recopied. The individual copying the order, if other than an RN, will follow the initialing procedures as previously described in *c*(3)(*b*) above. The responsible RN will verify these orders by initialing the proper column. If the RN recopies the orders, the only required authentication will be the nurse's signature at the end of the recopied orders.

(2) In the event that orders need to be recopied before the Date Completed column is filled, the order is indicated as recopied by a diagonal or single line drawn across the remaining blocks. Recopied/date/initials are written above the line. Existing initials are bracketed to indicate no further use of the remaining blocks.

2–9. DA Form 4678 (Clinical Record—Therapeutic Documentation Care Plan (Medications))

a. Purpose. This form, printed on white paper, is for medication orders and accompanying nursing orders which pertain to the administration of the ordered medication. Medication orders will be transcribed from DA Form 4256. Nursing orders pertinent to medication administration, initiated by the RN, and written on this form, will be indicated by placing NIO/nurse's initials in the Verify By Initialing column. Overprints of physician or nurse orders may be printed on the form per appropriate command or local policy.

b. Preparation. Enter all patient identification data as indicated on the form.

c. Content.

(1) *Allergies.* Specify the presence or absence of allergies. When known, indicate specific allergen.

(2) *Primary diagnosis.* Enter current diagnosis. Add other diagnoses if they significantly affect care to be given.

(3) *Recurring medications.*

(a) Order date. Enter the date of the current order.

(b) Initialing. The clerk or nurse who transcribes an order must initial the specified block. If other than the RN transcribes the order, an RN must initial the order at the earliest possible time. The RN's initials indicate that the nurse verified the transcription against the order on DA Form 4256 and is, therefore, accountable for its accuracy and its appropriateness from a nursing standpoint.

(c) Recurring Medications, Dose, Frequency. This column is used for recurring drug administration, including controlled substances, or actions when compliance with the order is repetitive and scheduled. The complete order, as originally written, must be transcribed to this section.

(d) Hour. Specific times are listed vertically. Each space is for a separate time of administration. Orders that are pervasive throughout the shift and are not time–related or sensitive (for example, intravenous (IV) rates, oxygen administration, etc.) are indicated by designating the inclusive times for each shift; for example, 07–15, 15–23, and 23–07. The abbreviations D, E, and N will not be used.

(e) Date. The top row of spaces is used to indicate the date the action is accomplished or medication is administered.

(f) Initialing. The nurse will initial the block opposite each specified time for administration and under the appropriate date column to verify compliance with the order. The patient's response to the medication may also be indicated. When placed in the designated block, the nurse's initials indicate that the medication has been

administered. The nurse's initials should be recorded on the first line under the appropriate date and the response code should be recorded in the block under the initials. The nurse's initials with the letter "(E)" indicate that the administered medication was effective. It achieved the desired results. For example, meperidine given for pain relieved the pain or diazepam given for agitation had a calming effect on the patient. The nurse's initials with "(I)" indicate that the administered medication was ineffective. This notation requires a note on the SF 510 to describe the patient's status and the actions taken to address the patient's condition.

(g) Discontinued order. When a single order is discontinued, draw a horizontal line across the remaining blocks. If multiple orders are discontinued, draw a diagonal line across the remaining blocks. Write DC/date/time/initials on the line. For quick, visual recognition of a discontinued order, a yellow highlighter or accent pen, which will not penetrate the paper or obliterate the writing, may be used to line over the order and the remaining unused blocks.

d. Single order action, pre–operatives. A single action medication order which is not completed within the verifying RN's tour of duty becomes a delayed order and is transcribed to this section.

(1) *Order date.* Enter the date of the current order.

(2) *Initialing.* Same as in *c*(3)(*b*) above.

(3) *Single Order, Pre–operative.* The complete order, as originally written, must be transcribed to this column.

(4) *Date/Time To Be Given.* Enter the date and time, if known, the drug is to be administered. Write in "on call" if so ordered.

(5) *Completed order.* The nurse who administers the medication enters the date, time, and his or her initials. If the order is not implemented; do not initial, place a circle in the block and specify the reason on SF 510.

e. PRN medications. Use when the time of administration is not predictable.

(1) *Order/Expir Date.* Enter the date the current order is written in the top portion. If applicable, enter the expiration date in the bottom portion.

(2) *Initialing.* Same as *c*(3)(*b*) above.

(3) *PRN Medication, Dose, Frequency.* Indicate the medication to be administered, dose, route, frequency, and reason (for example, meperidine 50 mg, IM q.4H prn, pain). The patient response may be documented as described in *c*(3)(*f*) above or on the SF 510.

(4) *Time/Date Dispensed.* Each block indicates a separate action. The person administering the medication enters the time, date, and initials at the time of completion.

f. Recopied orders.
(1) When space in the Date Dispensed column is filled, a double line is drawn across the entire page just below the last entry. Directly below the double line, or on a blank DA Form 4678, write "Recopied Orders," the dates for the upcoming days, and recopy each order still in effect, including the date the original order was written. The individual copying the orders will follow the initialing procedures as previously described in *c*(3)(*b*) above. The responsible RN will verify these orders by initialing the proper column. If the RN recopies the orders, authentication will be by the nurse's signature at the end of the recopied orders.

2–10. SF 510 (Clinical Record—Nursing Notes)

a. General. Nursing notes provide a chronological record of the nursing care provided, the patient's status, and/or responses to nursing interventions. The documentation should reflect any change in condition and results of treatment.

b. Preparation. Enter all patient identification data as indicated on the form. Each entry by nursing personnel will be preceded with the date and time of entry and, if applicable, the nursing care plan problem and number to be addressed in the note. Each entry will be followed by the signature with rank and title of the person making the entry.

c. Admission note. If the DA Form 3888 is completed at the time of admission, an admission note does not need to be recorded on the SF 510 except to note that the DA form 3888 was completed. If DA Form 3888 was not completed at the time of admission, an admission nursing note must be recorded that includes the date, time, manner of admission, reported known allergies and a brief clear description of symptoms and pertinent observations.

d. Discharge note. If the DA Form 3888–3 has been completed prior to or at the time of discharge, a discharge note does not need to be recorded on SF 510. A notation should be made on the SF 510 "Patient discharged. See DA Form 3888–3." In the absence of a discharge summary form, an entry must be recorded in the nursing notes which includes the date, time, manner of discharge and a concise summary of the discharge plan, the patient's progress toward achieving nursing goals, and the name of the person or agency accepting responsibility for the patient.

e. Content. Documentation of nursing care is pertinent, concise, and reflects patient status. Nursing interventions and patient status are noted including the patient's response to medical orders, the patient's response to the implementation of the individualized nursing care plan, and the applicable nursing standards of care. Documentation will also indicate when the patient and family have received instructions, and their level of understanding of the instruction.

(1) *Format of notations.* Notes may be narrative style or problem oriented. No specific format is mandated. However, components of the nursing process; that is assessment, planning, implementation, and evaluation, should be evident in the notes. Problem oriented charting problems should be identified by name and number.

(a) Each notation will be preceded with the date and time of the entry. The specific time the note is being written should be indicated. Block charting (for example, 0700–1500) is not authorized.

(b) All notes will end with the signature and rank and title of the person making the entry as specified in 2–2*b* above. As necessary a line will be drawn to eliminate unused space.

(2) *Out of sequence entries.* An entry may be made out of chronological order by noting the date and time of the entry followed by a statement that this recording is out of sequence (that is, a delayed entry).

(3) *Errors.* A mistake is not erased. A line is drawn through the error; "error" is noted and the reason for the error given with the initials of the writer followed by a notation of the correct information. The error is not to be obliterated.

g. Frequency of charting. Frequency of charting will be dictated by the patient's acuity, response to treatment and the judgment of the professional nurse responsible for the care of the patient.

(1) Minimally, Category 4, 5, and 6 patients will have one entry per shift, Category 2 and 3 patients once a day, and Category 1 patients once a week.

(2) If no notation appears, it indicates that the previous status exists. The patient received care as ordered; no abnormal observations were made and no unusual activities or incidents were noted.

(3) Any "STAT" procedures and medications which were necessitated by a change in the patient's condition, must be documented on the SF 510.

(4) Documentation of patient transportation to and from the following areas is mandatory: OR, recovery room, treatment off the MTF premises, and transfer to another unit. It is not necessary to chart routine successful transportation to various treatment areas such as physical therapy, radiology, etc. Exceptions, however, will be charted.

h. Documentation. Documentation on any form by other than the RN does not absolve the RN (that is, clinical head nurse, charge nurse, team leader, etc.) of the responsibility for professional supervision and review of nursing care and the appropriateness of documentation.

i. Student nurse charting. The policy for student charting will be determined by the chief, department of nursing at the MTF and the faculty representative of the nursing program.

2–11. DA Form 3888–3 (Medical Record—Nursing Discharge Summary)

a. Purpose. DA Form 3888–3 is used to facilitate summarizing the patient's status at the time of discharge from the MTF. It is a

three–part carbonless form, one copy of which is the patient's copy of the discharge instructions.

(1) Areas of instruction and patient response have been documented elsewhere in the patient record (progress notes, nursing notes, approved patient education flowsheets, etc.). The discharge summary pulls together information spread throughout the chart.

(2) When completed at the time of discharge, DA Form 3888–3 replaces the discharge note on the SF 510. All that is required on the SF 510 when the discharge summary is completed is "Patient Discharged; see DA Form 3888–3," or words to that effect.

b. Preparation. DA Form 3888–3 is a three–part carbonless form. The original copy becomes part of the patient's ITR (filed in DA Form 3444 series folder); the second copy is reviewed with the patient and retained by the patient or family, and the third copy is placed in the HR or OTR (filed in DA Form 3444 series folder).

(1) Entries may be made by all nursing personnel. The RN is responsible for ensuring the accuracy and completeness of the entries, and for reviewing the instructions with the patient or significant other person prior to discharge.

(2) All patient identification information is to be entered in the space provided on the form.

c. Content. Information on this form should be pertinent, factual, and written in terms understood by the patient and family.

(1) Complete the form as specified by each section of the summary.

(2) The writer's initials, followed by "yes" or "no," as appropriate, are recorded in all blocks related to patient understanding of instructions.

(3) "N/A" is placed in those spaces not applicable, or where notation is unnecessary.

2–12. SF 511 (Clinical Record—Vital Signs Record)

a. Preparation. Enter the patient's identification data here and in the space at the bottom of the form.

b. Recording data. Number the "Hospital Day" line of blocks with the day of admission as 1, and continue consecutively. Use the post–day line as applicable. The day of surgery is the operative day. The day following surgery is noted as the first post–operative day. The day and hour blocks will be properly labeled. Represent temperature by dots (.) placed between the columns and rows of dots and joined by straight lines. If the temperature is other than oral, it should be indicated by (R) for rectal and (A) for axillary. Show pulse determination by use of a circle (O) connected by straight lines. Enter the respiration and blood pressure on the indicated rows below the graphic portion. Record frequent blood pressure readings on the form's graphic portion by entering an "X" between the columns and rows of dots, at points equivalent to systolic and diastolic levels. Connect the two with a vertical solid line. Use blank lines at the bottom of the sheet to record special data such as the 24–hour total of the patient's intake and output.

2–13. SF 536 (Clinical Record—Pediatric Nursing Notes)

This form may be used for pediatric patients to replace the SF 510.

2–14. SF 537 (Medical Record—Pediatric Graphic Chart)

This chart is similar to SF 511 and may be used for pediatric patients.

2–15. SF 539 (Medical Record—Abbreviated Medical Record)

When authorized by AR 40–66, SF 539 may be used in place of DA Form 4256, DA Form 4677, DA Form 4678, SF 510, and SF 511.

2–16. DA Form 4700 (Medical Record—Supplemental Medical Data)

DA Form 4700 will be used to provide special information to supplement other authorized forms that do not meet local requirements under AR 40–66. DA Form 470 may be used without prior authorization to document signature and initial verification lists.

Chapter 3
Temporary Nursing Records

3–1. PCN: DXXXX–NAC–6G01, DA Form 7006–E (Personnel Time Schedule Worksheet), PCN: DXXXX–NAC–G02, DA Form 3872–1–E (Personnel Time Schedule), and DA Form 3872 (Nursing Service Personnel Time Schedule)

a. PCN: DXXXX–NAC–6G01, DA Form 7006–E will be maintained by all department of nursing/nursing service activities. This record is a computer printout processed in accordance with the Uniform Chart of Accounts Personnel Utilization System to record nursing personnel utilization data. It provides a roster of personnel, displays on–duty and off–duty time, and explains absences from the workcenter by use of exception codes. Planning and preparation of the schedule is a responsibility of the clinical head nurse or other persons designated by the chief, department of nursing or nursing service. Submission of schedules and the process for making changes will be determined by locally established policy.

b. Two different DXXX–NAC–6G01, DA Form 7006–Es are used: prospective schedules and retrospective schedules. Prospective schedules are normally produced at least 2 weeks in advance for workcenters that need to project staffing requirements. Retrospective schedules are prepared for workcenters where advance scheduling is not required. All DXXX–NAC–6G01, DA Form 7006–Es will be updated after the week has been worked to reflect the actual schedule worked. Manpower data from the Uniform Chart of Accounts, Uniform Staffing Methodologies, and Schedule–X will be based on the information provided on these updated time schedules. Schedule worksheets will be retained as references for 2 months. They may be held for longer periods if required locally and destroyed when no longer required.

c. A computerized PCN: DXXXX–NAC–6G02, DA Form 3872–1–E will be automatically generated for workcenters utilizing the prospective schedule worksheet. This abbreviated schedule should be posted at least 2 weeks in advance to communicate schedule information. Time schedules for a year must be available for review by the Joint Commission on Accreditation of Healthcare Organizations. The filing of the computerized PCN: DXXXX–NAC–6G02, DA Form 3872–1–E should be established by local policy.

d. A manual copy of DA Form 3872 will be used at workcenters where the automated Uniform Chart of Accounts Personnel Utilization System has not been implemented. This time schedule should be prepared and posted in advance to relay schedule information. Abbreviations will be used as listed on the form and as established by the chief, department of nursing/nursing services. Schedules will be retained as references for the current year and the previous year.

3–2. DA Form 3889 (Nursing Unit 24–Hour Report) and DA Form 3889–1 (Nursing Unit 24–Hour Report—Continuation Sheet)

a. General. The nurse in charge or other person designated by the chief, department of nursing/nursing service, is responsible for the report. The manner of its preparation and submission will be established locally.

b. Purpose. The purpose of this report is to inform the chief, department of nursing regarding patients and their conditions. This information provides administrative personnel with a substantive report of patient care activities within the department of nursing. The report will give a concise and accurate portrayal of ward activities during each period covered. It should furnish the chief, department of nursing, with data required to manage resources and disseminate patient care information.

c. Content. Patients to be reported will include those who are on

the very serious or seriously ill list and those designated locally as command interest. Information includes census and patient movement figures. Unusual occurrences or accidents, and other matters which would be of interest to the chief, department of nursing/ nursing service and to the commander should also be documented.

3–3. DA Form 3950 (Flowsheet For Vital Signs and Other Parameters)

This form is a worksheet or a flowsheet to record temperature, pulse, blood pressure, and respiration or the columns may be labeled as needed. Vital signs for a group of patients can be recorded and subsequently transcribed to the graphic record (SF 511 or SF 537) of the individual patient. The worksheet may be destroyed after the readings have been transcribed to the individual patient's graphic record. When used as a flowsheet to record frequent vital signs or other parameters for an individual patient, the DA Form 3950 will be filed in the patient's ITR.

3–4. DA Form 4028 (Prescribed Medication)

When unit dose is not provided, this card will be prepared whenever a medication is prescribed. The purpose is to ensure that patients receive medications of the kind and quantity prescribed for them. The card will be destroyed upon change of orders. This card is not used when unit dose pharmacy support is provided.

3–5. DA Form 3887 (Nursing Department—Army Nurse Corps Data)

This form is maintained by the office of the chief, department of nursing/nursing service. It is used as a source of professional and personal information on AN officers and assists in their assignment and responsibilities within the activity. Individual officers will ensure that data on the card are current, and that necessary changes or new information are reported to the chief, department of nursing/ nursing service.

3–6. DA Form 3951 (Nursing Service—Assignment Roster)

This form is an optional worksheet that documents assignment of duties to be accomplished by nursing personnel. It will indicate the individual areas of responsibility of a clinical head nurse or other designated person. The worksheet may be destroyed at the end of the covered period.

3–7. DA Form 4015 (Nursing Care Assignment)

This form is a worksheet that shows the patient care needs and related activities assigned to individual nursing personnel. It will be utilized as needed by the clinical head nurse or designated charge nurse. Its purpose is to align the nursing care needs of the patient with the personnel resources available and to carry out related assignments. This form is used in conjunction with DA Forms 3888, 3888–2, 3888–3, 4677, and 4678. DA Form 4015 should be destroyed when assignments have been accomplished and recorded or reported, as appropriate.

3–8. DD Form 792 (Twenty–Four Hour Patient Intake and Output Worksheet)

This worksheet is used to record all fluid intake and output. It is completed by nursing personnel. After the totals have been recorded on the graphic records (SF 511 or SF 539), the worksheets should be destroyed. The worksheet should not be filed in the ITR.

3–9. DD Form 1924 (Surgical Checklist)

This form will be placed on the front of each patient's chart prior to surgery. It provides a visual check of the medical forms and procedures required prior to arrival in the operating suite. The DA Form 1924 is designed to permit use of the addressograph to complete the patient's identification. The inpatient identification plate will be placed in the envelope provided on the form and will remain with the DA Form 1924 until the patient returns to his or her ward. Nursing personnel will place their initials in the proper columns as

each preoperative check and procedure is completed. The RN releasing the patient to the OR staff members will sign this form at the time of release. The form will be destroyed when no longer required.

Chapter 4
Community Health Nursing Records

4–1. DA Form 3762 (Army Health Nursing—Family Record)

a. General. A family record will be initiated on DA Form 3762 for each family receiving community health nursing services when it becomes apparent that more than two home visits are necessary. This record provides a means for recording family identification, health and socio–economic data, and nursing services rendered to patient and family. It assists the nurse in identifying patient and family needs and in planning and evaluating their care.

b. Recording data. The provisions of paragraphs 2–2 and 2–3 apply. The problem oriented methods utilizing the SOAP or SOAPIE (Subjective, Objective, Assessment, Plan, Implementation, and Evaluation) format will be used to record initial and all subsequent visits. Notes will be clear and concise. Consultations on behalf of the patient or family will require brief summarization. Upon termination of community health nursing services, a discharge summary will be written and the record closed. SF 600 (Chronological Record of Medical Care) will be used when additional pages are required.

c. Filing. Records will be filed alphabetically in the community health nursing office per AR 25–400–2. Closed records will be filed in the inactive section. Records will be handled so that unauthorized personnel do not have access to them.

d. Disposition. Destroy these records 3 years after they are closed. When requested, a summary of record may be sent to another installation.

4–2. DA Form 3763 (Community Health Nursing—Case Referral)

a. General. This form provides a means for medical and allied health personnel to refer individuals and families for nursing services. The community health nurse may use the form to refer patients to other military and civilian health and welfare agencies, or to community health nurses at other military installations. This form helps to provide continuity of care, minimizes duplication of effort, and furnishes accurate information.

b. Preparation and disposition. The form will be prepared in triplicate by the Service or individual initiating the referral. A physician's signature is required when medications and treatments are ordered. Referral which contains medical information will require written consent of the patient or legal representative prior to release to a civilian agency. When the referral is to a civilian agency, two copies will be forwarded and the third retained in the community health nursing files. After acting on the request, the recipient will record findings and recommendations on the reverse side of the form. One copy is returned to the initiator, then filed in the patient's HR or OTR (DA Form 3444 series folder). The second copy will be retained in the community health nursing files. When the community health nurse renders the service, the third copy may be destroyed. If a family record is initiated, the referral form is filed with the family record.

4–3. DA Form 3760 (Community Health Nursing—Family Index)

a. General. This form provides a means of identifying families receiving community health nursing supervision. It helps to determine the case load by program classification and to schedule visits.

b. Preparation and disposition. A form will be initiated for each family or individual receiving community health nursing supervision. Make entries as indicated on the form. Program classifications are health promotion, communicable disease control, chronic disease

control, and family health and support services for high risk families. Forms are filed alphabetically in the active file until the family record is closed, in the inactive file for 3 years, and then destroyed. Staff nurses may use this form as a working file to provide a reminder of services needed at a particular time. Destroy forms when no longer needed.

4–4. Inpatient treatment records and health records and outpatient treatment records (records filed in the DA Form 3444 series 1 to 9, Alphabetical and Terminal Digit File for Treatment Record)

a. General. AR 40–66 and AR 40–400 specify the policy and procedures for the Army's medical records system.

b. Procedure. It is essential that the patient's medical records reflect the health services rendered by community health nurses. All treatment, pertinent observations and instructions will be recorded on SF 600 in the HREC or OTR, except on initial visits when DA Form 3763 is to be used. When the HREC or OTR is not available, SF 600 will be initiated for filing in the patient record. Entries in the ITR (DA Form 3444 series folder) will be on SF 510. For example, an entry is made when the community health nurse instructs and counsels a hospitalized diabetic patient.

Chapter 5
Operating Room and Anesthesia Records

5–1. General
OR and anesthesia records and forms are used to schedule and record events that support all surgical procedures performed within the hospital or clinic. When OR and/or anesthesia personnel have been asked to attend or monitor patients, they will record procedures on these forms. For uniform reporting and recording for statistical purposes, these forms may also be used in cardiac catheterization laboratories, outpatient surgical clinics, and other treatment areas where scheduled procedures do not normally require OR nursing and/or anesthesia services.

5–2. DA Form 4107 (Operation Request and Worksheet)
a. General. The medical or dental officer responsible for the patient's operation or special treatment will initiate and complete section A, DA Form 4107, except for items 20 and 21. Section B will be completed by the anesthesiologist or nurse anesthetist providing care for the patient. Where no anesthesia representative is assigned or present, nursing personnel should complete section B of DA Form 4107.

b. Purpose. This form is intended to schedule and record all surgical procedures performed in the main ORs and ambulatory surgery center. When anesthesia and/or OR nursing personnel are required to attend or monitor patients, DA Form 4107 will be used (for example, obstetrical suite, special procedures x–ray clinic, and cardiac catheterization).

c. Detailed instructions.
(1) *Section A—Request for Surgery.*
(a) *Items 1 through 14.* Self–explanatory.
(b) *Item 15.* If purulent material or infectious conditions are present or anticipated, write "yes."
(c) *Item 16.* Self–explanatory.
(d) *Item 17.* Self–explanatory.
(e) *Item 18.* Self–explanatory.
(f) *Item 19.* Note special instructions, to include special solutions for prepping.
(g) *Item 20.* Chief, operating room nursing section or designee will note name(s) of scrub person(s) followed by name(s) of circulator(s).
(h) *Item 21.* The chief of anesthesia and operative service or designee will complete.
(i) *Item 22.* Indicate type of anesthesia desired (for example, general, regional, local, or topical).

(j) *Item 23.* Indicate special instruments and/or equipment other than routine (for example, power equipment, tray, tourniquet, etc.). In addition, indicate patient limitations (for example, deaf, mute, language barrier), which will assist operating room staff in planning patient care.
(k) *Item 24.* Self–explanatory.
(2) *Section B—Operation Worksheet.*
(a) *Items 25 and 26.* Self–explanatory.
(b) *Item 27.* Septic is defined by using classification of the operative wound, and applying the National Research Council criteria: Clean wounds, clean–contaminated wounds, contaminated wounds, and dirty–infected wounds.
(c) *Interns 28–32.* Self–explanatory.
(d) *Item 33.* Anesthesia Time: "Time Began" is defined as the beginning of patient preparation after the patient has arrived in the holding area of the surgical suite or satellite facility. This time commences with chart review and placement of IV lines, invasive monitors, and/or noninvasive procedures by anesthesia personnel. "Time Ended" means actual clock time at which the anesthesia provider leaves the patient in the post anesthesia recovery unit, intensive care unit, or other post surgical unit.
(e) *Items 34–38.* Enter agents and techniques. If none, indicate by lining out the appropriate space(s).
(f) *Item 39.* Note adjunctive procedures not intrinsically a part of delivery or routine anesthesia such as hypothermia, anesthesia by tracheotomy, central venous pressure monitoring, Swan–Ganz monitoring, transvenous pacemakers, and arterial lines.
(g) *Item 40.* "Time Began" means the actual clock time the nursing team began preparation in the room assigned for the case. "Time Ended" means actual clock time the cleaning of the room is completed and ready to receive the next patient. Note, these times will not be the same as anesthesia or operation times.
(h) *Items 41–44.* Self–explanatory.
(i) *Item 45.* Note number(s) and type(s) of drain(s).
(j) *Item 46.* Indicate "None," "Correct," or "Incorrect." Enter the last name of the professional nurse who performed and verified the sponge count.
(k) *Item 47.* Identify the specimen or tissue and state the time and date it was sent to pathology or what disposition was made of the specimen or tissue.
(l) *Item 48.* Self–explanatory.
(m) *Item 49.* Indicate the total episodes of surgery by using the following definitions.
1. Episode of OR Nursing. An episode of OR nursing is based on a combination of two factors: OR personnel and time. One episode of OR nursing is assigned for the initial 3 hours or fraction thereof, for one nursing team. An OR nursing team consists of one scrub person and one circulating person. OR nursing personnel are permanently assigned to the OR. Each additional OR nursing person for a particular case equals 0.5 episode.
2. Episode of Anesthesia. An episode of anesthesia is also based on a combination of two factors: anesthesia personnel and time. One episode of anesthesia is counted for the initial 3 hours or fraction thereof for one anesthesia provider. Any fraction over the initial 3–hour period is an additional episode. One episode is also added for each additional anesthesia provider fully assigned to the case.
3. Method of Calculation: The following case scenarios provide examples for calculation of episodes of OR nursing and episodes of anesthesia (fig 5–l).
(n) *Item 50.* Enter any complications that occurred in the OR or those unusual situations in the preoperative period that relate to the anesthesia or surgical experience.
(o) *Item 51.* When a dictation capability exists, physicians will sign their names after completion of dictation.
(p) *Recorded in Register.* After the case has been recorded on the DA Form 4108 (Register of Operations) or entered into the automated data processing system, the person initiating this task will show completion by initialing.
c. Disposition. The form consists of four copies. Upon completion of section B, DA Form 4107 is separated. Retain the original copy in the OR section until the information is transcribed to DA

Form 4108 and SF 516 (Medical Record— Operation Report). Distribution of additional copies will be determined by the chief, anesthesiology and operative service. All copies may be destroyed when no longer needed.

Example 1

The personnel needed for the patient undergoing myringotomy with tube insertion taking 45 minutes: There is one OR nursing team and one anesthesia provider. The case equals one episode of OR nursing and one episode of anesthesia.

Example 2

The personnel needed for a patient undergoing a cholecystectomy with intraoperative cholangiogram taking 4 hours: There is one OR nursing team and one additional circulator who is used for 1 hour and there is one anesthesia provider. The case equals 2.5 episodes of OR nursing and two episodes of anesthesia.

Example 3

The personnel needed for the patient undergoing an exploratory laporotomy for repair of a ruptured abdominal aneurysm taking 10 hours: For 3 hours there is one OR nursing team plus an additional scrub and two additional circulators, for the next 4 hours, there is one OR nursing team and two additional circulators, for the last 3 hours there is one OR nursing team, there are two anesthesia providers for the first 6 hours of the case, and for the next 4 hours there is one anesthesia provider. The case equals seven and one–half OR nursing episodes and six episodes of anesthesia; there is one anesthesia provider.

Figure 5-1. Examples for calculation of episodes of OR nursing and episodes of anesthesia

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5–3. DA Form 7001 (Operating Room Schedule)

a. General. DA Form 7001 is prepared daily for the next day reflecting all scheduled operative and anesthesia procedures, additional procedures, such as emergencies, and for changes to the OR schedule. Incorporating elements from section A of DA Form 4107, prepare DA Form 7001 either on the cutsheet version or on offset masters for printing of duplicate copies.

b. Preparation and distribution. Entries may be typed or hand-written, if they are legible. Additionally, DA Form 7001 can be prepared electronically and may be duplicated for distribution. It serves as a central communication tool concerning surgery. DA Form 7001 covers a 24–hour period beginning at 0000 and ending at 2400. Cases beginning on l day and ending on the next day should be posted on the beginning day's schedule (that is, started the case at 2300, 24 Sep 91 and ended at 0200, 25 Sep 91. The case should be recorded on the schedule for 24 Sep 91).

c. Use. The original DA Form 7001 can be used to verify data recorded on DA Form 4107 prior to entry onto DA Form 4108. Duplicated DA Form 7001 can be used for patient transport identification slips, individual operating room case slips, Centralized Materiel Service instrumentation verification, quality assurance tracking and trending, pre– and postoperative statistical data, anesthesia interview assignments, progression of operative schedule, completion and/or cancellation of cases, mass casualty exercises, staffing of personnel, and any other pertinent patient information (for example, special care needs for transport).

d. Detailed instructions.

(1) *Item 1.* Enter the name of the MTF.

(2) *Item 2.* Self–explanatory.

(3) *Item 3.* Enter the time the case is scheduled to begin and in what specific (number) OR; for example, 0730, OR #l.

(4) *Item 4.* Enter the patient's full name, identification category, age, and religion; for example, Williams, John D., AD, 18, P.

(5) *Item 5.* Self–explanatory.

(6) *Item 6.* Enter the ward from which the patient is sent to surgery and the ward or specialty care unit to which the patient will go after surgery (for example, from 64 to RR).

(7) *Item 7.* Enter the proposed surgery as recorded on DA Form 4107, item 9 (for example, exploratory laparotomy, possible bowel resection).

(8) *Item 8.* Enter the names of all operating surgeons with the primary surgeon first (for example, Dr. White and Dr. Smith).

(9) *Item 9.* Enter the name and status of the OR nursing personnel scrubbing and circulating. Indicate scrub with (S) and circulator with (C) (for example, SGT Tamp (S) and CPT Rowe (C)).

(10) *Item 10.* Enter the names of all the anesthesia providers to include physician staff personnel (for example, MAJ Down, MC or Dr. Jones).

(11) *Item 11.* Enter the anesthetic as indicated on DA Form 4107, item 22. Enter blood and associated products as indicated on DA Form 4107, item 14 (for example, General/WB 2000 cc FFP 1500 cc).

e. Disposition. Destroy upon completion of entry of data onto DA Form 4108, or when no longer needed as deemed by local policy.

5–4. DA Form 4108 (Register of Operations)

a. General. This is a record of all surgical procedures performed. Normally, it will be kept and maintained in the OR suite. Where surgical procedures or anesthesia monitoring is undertaken outside the OR suite (for example, obstetrical suite, urology, cardiology, plastic, dental clinic, etc.), an individual DA Form 4108 will be maintained by the respective department, service, or clinic. Information from the completed DA Form 4107 will be transcribed to DA Form 4108. Accuracy and completeness of the register is imperative since this document may be used for statistical computations, research, feeder reports to higher headquarters, and hospital accreditation, as well as support for staffing and space requirements.

b. Availability. Covers for the chronological collection of each year's DA Forms 4108 are available through supply channels.

c. Arrangement. Arrange pages chronologically with monthly calculation of total procedures. Sequence number 1 is the first procedure begun from 0001 on the first day of the month. The final sequence number for the month is the last procedure begun before 2400 on the last day of that month. Pages will be numbered in the space provided in the upper right corner. Both sides will be used. At the end of each month, tally figures may be entered in the margin, and the cumulative total carried to the upper left corner of a new page to begin a new month's record. Suitable tabs may be affixed to identify the month.

d. Recording of data. Entries may be typed or handwritten if they are legible. Entries are adaptable for computer input.

e. Corrections of errors. Erasures are prohibited. A line will be drawn through an incorrect entry. Initials of the person making the entry will be placed above the lined portion. Correct information will be recorded following the lined entry.

f. Detailed instructions. See paragraph 5–3*b* for entry assistance.

(1) *Hospital.* Enter the name and location.

(2) *OR number.* Enter #1, #2, #3, etc.

(3) *Emergency.* Indicate with an "X" if an emergency procedure is used.

(4) *Case number.* Sequence within the particular OR number noted in (2) above.

(5) *Surgeon(s).* The surgeon is listed first, followed by assistants in descending order.

(6) *Combat.* Use currently acceptable medical letter combination or abbreviation to indicate the source of injury if the result of hostile fire.

(7) *Nursing time.* Indicate time "Began" and time "Ended" from DA Form 4107.

(8) *Counts.* Indicate after each (for example, sponge, needle or sharp, instrument) "C" for correct, or "IC" for incorrect.

g. Disposition. These binders will be disposed of under AR 25–400–2. Maintain from one Joint Commission on Accreditation of Healthcare Organizations visit to the next and for the time required

by statutes of limitations. Additionally, maintain as deemed by local policy.

5–5. DA Form 5179 (Medical Record—Preoperative/ Post–operative Nursing Document)

a. General. This form consists of a nursing assessment and generalized care plan for patients undergoing an operative procedure, and a postoperative evaluation. This form is to be prepared by an RN and will be a permanent part of the patient's clinical record. Data collection and review of the care plan is to be accomplished with the patient prior to the operative procedure. If unable to obtain data; for example, emergency surgery, document this in item 5. Item 11 is to be completed within 24 hours of the procedure.

b. Purpose. This form provides a record of the continuation of the nursing process from the time the patient leaves the ward or unit to go to the OR until the patient returns to a receiving unit.

c. Detailed instructions.

(1) *Items 1–4.* Self–explanatory.

(2) *Item 5.* Provides space for additional information such as family requests, information not identified in items 6–8 of the form.

(3) *Item 6.* Lists potential problems and/or needs of the patient. If the stated problem is relevant to the patient, an "X" should be placed in the area provided at the beginning of each statement and the problem statement completed by filling in each blank. A space is provided to write additional problems and/or needs.

(4) *Item 7.* States expected goals and outcomes. A space is provided to write additional goals and outcomes, if necessary.

(5) *Item 8.* Lists OR nursing interventions. The interventions not applicable to the patient are to be lined out and initialed. Space is provided for documenting additional interventions.

(6) *Item 9.* Self–explanatory.

(7) *Item 10.* Signature of RN completing Item 8.

(8) *Item 11.* Must be completed within 24 hours after completion of the operative procedure. Each patient problem and/or need identified in Item 6 must be evaluated here.

(9) *Items 12–13.* Self–explanatory.

5–6. DA Form 5179–1 (Medical Record—Intraoperative Document)

a. General. This form documents the care of each patient undergoing an operative procedure. The form is to be initiated prior to the operative procedure and completed after the operation. The form is to be prepared by an RN and will be filed on the right side of the ITR (DA Form 3444 series).

b. Detailed instructions.

(1) *Item 1.* Record how the patient arrived; that is, via litter, wheelchair, or bed; and by whom transported.

(2) *Item 2.* Verify, by RN, with payroll signature with rank and corps or civilian grade; for example, Mary S. Smith, CPT, AN or Betty T. Jones, RN, GS–10.

(3) *Item 3.* Specify day, month, year; use the military time the patient entered the main operating suite door.

(4) *Item 4.* Record the time the patient enters the OR and specify OR number plus case number for that room; for example, OR # 1 case 1.

(5) *Item 5.* Check descriptive word that best describes patient's preoperative status and any other appropriate comments.

(6) *Item 6.* Record names and titles of assigned personnel (permanent staff) and others such as student personnel, relief personnel (i.e., meals, change of shift).

(7) *Item 7.* Specify intraoperative position of the patient; record any other position(s); for example, split leg, and all positional devices or aids under comments. Draw or annotate any device or aid and its placement in Item 9.

(8) *Item 8.* Indicate the hair removal method in the appropriate box with "X" if hair removal is done by OR personnel; record the name of the individual performing procedure. Record type of site preparation solution and its strength (for example, 1%, 2%); site of preparation; and who performed preparation. Insert any appropriate comments such as skin conditions or reactions, for either task.

(9) *Item 9.* Record placement of indicated items by appropriate legend. Record other external devices such as blood pressure cuff, electrocardiogram electrodes or any other devices required by local facility policy or standing operating procedure.

(10) *Item 10.* Check YES (done) or NO (not done) for each count listed. Record each count as correct "C" or incorrect "IC" : if incorrect make an explanatory entry in section l9. If "Other" is YES, add type of count and body space or cavity; for example, urinary bladder. Scrub and/or circulating personnel doing the count(s) should be identified by name.

(11) *Item 11.* Self–explanatory.

(12) *Item 12.* Record if electrosurgical unit (ESU) was used by "X" in the YES or NO block. Enter medical maintenance control number for every ESU and bipolar unit used and any other information required by local facility policy (for example, manufacturer and model number). Record grounding pad(s) used (brand and lot number) and any other information required; that is, name of individual applying or removing pad.

(13) *Item 13.* List prosthesis or implant (for example, bone, screws, plates, vascular grafts, hulka clips, etc.) with manufacturer and identification numbers (lot number, quality control number) if available; attach sticker labels from implants if available.

(14) *Item 14.* Record any medications that the patient receives in the operating room not given by anesthesia personnel. Note wound irrigations as follows: NSS = normal saline solution; BSS = balanced salt solution; method of irrigation (for example, pulse, asepto, lavage), and when indicated; for example, for pediatric patients, note amount. Medications and orders are to be signed by the physician as stated in paragraph 2–4 for DA Form 4256. Other orders or treatments are those performed during the operative procedures; for example, catheterization.

(15) *Item 15.* Record x rays and sites as indicated; specify special techniques (for example, fluoroscopy), and/or equipment (for example, C arm).

(16) *Item 16.* Enter "X" in the YES or NO blocks for specimens sent to the laboratory. Identify in NAME spaces the specimens sent to the laboratory by type and source or tissue; use FS for frozen section and C for culture. Examples: FS, nodule left vocal cord; C, anaerobic, gallbladder. If there are more than 11 specimens, record them in item l9.

(17) *Item 17.* Identify tubes, drains, and packings used by type, size, and site; for example, "vaseline gauze, 1/4 inch, L nostril. "

(18) *Item 18.* Record any immobilizers used, type(s) of dressing applied and location(s). Examples: Posterior splint cast, Telfa, xeroform, dry sponge, etc., also see item 17.

(19) *Item 19.* Use this section for further documentation or for reporting additional information on other items.

(20) *Item 20, 21.* Self–explanatory.

(21) *Item 22.* Signed by the RN with payroll signature with rank and corps or civilian grade.

c. This form is adaptable for computer inputs.

Chapter 6
Nursing Activities Reports

6–1. Purpose

This chapter gives the policies and procedures to prepare and submit nursing activities reports. This chapter applies to all Army MEDCENs and MEDDACs. These reports are needed to give timely information on nursing activities and management data on nursing resources.

6–2. DA Form 4798–R (Nursing Activities Report) (RCS MED–369)

a. General. Prepare this report monthly and submit it not later than the 10th of each month. Selected information for this report may be obtained from data generated by the Uniform Chart of Accounts Personnel Utilization System. Data from health clinics and troop medical clinics that are part of the MEDCEN and MEDDAC

organization will be included. Show data from all clinics if the personnel are assigned to the department of nursing/nursing service for supervision. Nursing personnel strengths from health clinics located on other posts and installations should be listed in the Remarks section. DA Form 4798–R (RCS MED–369) will be locally reproduced on 8 1/2– by 11–inch paper. DA Form 4798–R is located at the end of this regulation for this purpose.

b. Reporting period. Enter the last calendar day of the reporting period, the month, and the year.

c. Section A and section B, Nursing Strength (Professional), (Paraprofessional).

(1) *Lines 1 and 2.* Required and authorized strengths should be derived from the current MEDCEN or MEDDAC table of distribution and allowances, modified table of distribution and allowances, or modified table of organization and equipment with approved changes.

(2) *Line 3.* Assigned strength should represent the actual number of nursing personnel assigned to the MEDCEN and MEDDAC as of the last day of the reporting period. This figure should include nursing personnel assigned outside the department of nursing, such as the nurse methods analyst and community health nurses. Personnel not assigned to the MEDCEN or MEDDAC, but who are attached or on loan for MEDCEN and MEDDAC functions, should be reported in section F, Remarks.

(3) *Column q, section A and column r, section B.* Total strength of the department should reflect the totals of columns e through p for Section A and columns c through q for Section B.

(4) *Remarks.* Place an asterisk in any column for which further explanation is required in section F, Remarks.

d. Section C, AN Officers Not Assigned to Department of Nursing.

(1) Identify the nurse methods analyst and community health nurses by name and rank.

(2) Identify any other AN officer(s) by name, rank, and assigned duty.

(3) Use the remarks section if additional space is required and for the number of any civilian or enlisted nursing personnel assigned outside the department of nursing.

e. Sections D and E, AN Projected Gains and Losses (Next 120 Days).

(1) Projected gains and losses should be listed by name, rank, area of concentration (AOC), estimated time of arrival or departure, and gaining or losing MTF. Actual gains and losses should be listed in the Remarks section.

(2) Reason for the loss (expiration term of service, reassignment, etc.) should be listed if known.

(3) If additional space is needed, continue projected gains and losses on a sheet of plain bond paper. Attach the sheet to the report.

f. Section F, Remarks.

(1) Fill in the name, rank, and primary AOC or MOS of the chief, nursing administration and the chief wardmaster.

(2) Use the Remarks section for information of interest to a higher headquarters.

(3) Specific items to include in section F are shown on DA Form 4798–R. Also note selections for educational programs; personnel actions, such as approval of Regular Army status; voluntary indefinite and retirement applications; temporary duty and absence for illness in excess of 15 days; officers assigned to a medical holding detachment; and Reserve Component personnel present for duty by unit, Individual Mobilization Augmentee, or Individual Ready Reserve status. If additional space is required, continue remarks on a sheet of plain bond paper and attach it to the report.

g. Roster. A roster of all AN officers including name, rank, AOC, skill identifier (Sl), and duty position will be attached to the monthly report on a quarterly basis for the periods ending 31 December, 31 March, 30 June, and 30 September. Submit in the format shown in table 6–l. The roster will be organized alphabetically and by grade and primary AOC. Under Special Notations record the duty assignment if it differs from that of the primary AOC.

Table 6–1
Format for roster of AN officers

Name	Grade	AOC/SI	Arrived from	Departed to	Special notations

6–3. DA Form 4800–R (Nurse Practitioner/Clinical Nurse Specialist Monthly Activities Report) (RCS MED–370)

a. Specific requirements. DA Form 4800–R will be reproduced locally on 8 1/2– by 11–inch paper. A copy for local reproduction purposes is located at the end of this regulation. See paragraph l–4*e* for specific reporting requirements.

b. Name and Rank/Grade. The individual nurse practitioner (NP) or clinical nurse specialist (CNS) will complete the Name and Rank/Grade blocks and include AOC and SI. This form is to be completed by both military and civilian NPs and CNSs.

c. Special instructions. See the back of the DA Form 4800–R for special instructions.

d. Section I, Identification.

(1) NPs and CNSs assigned to a health clinic physically remote from its parent MEDCEN or MEDDAC will use the code of the parent MEDCEN or MEDDAC. For example, an NP assigned to Andrew Rader Clinic will use the code listed for Walter Reed Army Medical Center. For this report only NPS and CNSs assigned to health clinics that were formerly a MEDDAC will continue to use the MEDDAC designation. For example, NPs assigned to the Health Clinic, Aberdeen Proving Ground, will use the code for Aberdeen Proving Ground.

(2) An NP or a CNS performing duties in more than one clinic will enter the code for the clinic accounting for the majority of his or her duty hours. Names of clinics vary in different MTFs. Select the clinic that most closely describes the type of clinic to which assigned.

e. Section II, Individual Patient Visits.

(1) For this report, an individual patient visit is defined as any encounter an NP or a CNS has with a patient on a one–to–one basis, regardless of the purpose.

(2) An NP or a CNS who makes ward rounds with other health team members should not count each patient visited by the team. Only visits made individually by the NP or CNS will be counted. For example, an obstetrics and gynecology (OB/GYN) NP making postpartum rounds with physicians and clinical head nurses would not count these encounters as individual patient visits.

f. Section III, Patient Visits by Category.

(1) Use only one subgroup of patient categories.

(2) Multiple purpose visits are accountable in the category that describes the main purpose of the visits. For example, an adult diabetic patient who visits an NP for treatment of an acute respiratory illness would be counted as an acute minor illness visit rather than a chronic illness visit. Do not count a visit in more than one category.

(3) Use only the options given on DA Form 4800–R for categories for patients. Visits that do not fit the categories will be counted as "Other."

g. Section IV, Croup Patient Activities. Group patient activities are defined as services provided by an NP or CNS to more than one patient simultaneously. Examples include a pediatric NP teaching a class on newborn care to a group of postpartum patients; an adult NP conducting a patient teaching seminar for diabetic patients; a psychiatric or mental health NP providing group therapy for patients; and an OB/GYN NP taking a group of prenatal patients on a tour of inpatient obstetrical facilities.

h. Section V, Time Data. Activities such as participation in teaching classes to student groups, in–service education programs, ward rounds with other healthcare team members, or speeches to community groups will be accounted for in Section V.

(1) The total number of sessions and attendees will be shown as a whole number; do not use decimals or fractions.

(2) The total number of hours will be shown as a whole number; do not use decimals or fractions.

i. Section VI, Duty Days.

(1) For this report, duty days refer to the total number of days the NP or CNS was present for duty at the MEDCEN or MEDDAC.

(2) Days off, leave days, administrative absences, hospitalization, sick in quarters, convalescent leave, holidays, and temporary duty absences will be deducted from the total number of duty days in the month.

6–4. DA Form 3761 (Community Health Nursing Activities) (RCS MED–371)

a. General. This form helps plan and evaluate services and provides data for periodic reports such as DA Form 2789–R (Medical Summary Report) (AR 40–400) and the Command Health Report (RCS MED–3) (AR 40–5). The DA Form 3761 is accompanied by a narrative that further describes the community health nursing services provided at the MTF; annually, an appendix should be attached to the January report listing the names of the staff, titles and frequency of committees that have community health nurse participation, and the names of the ongoing community health nursing programs.

b. Preparation. DA Form 3761 will be maintained by each community health nurse. The monthly total will be that for the last day of the month, since daily totals are cumulative. See paragraph 1–4*d* for routing instructions for the DA Form 3761 and the accompanying narrative report.

c. Specific reporting requirements.

(1) *Visit.* A visit is seeing a person for health services or giving health advice or consultation over the telephone that is significant enough to record on the person's HR or OTR (DA Form 3444 series folder) in accordance with the definition of "visit" in the glossary of AR 40–400. Record telephone visits under section A, column f. All telephone contacts, including telephone visits, are recorded in section D, line 32.

(2) *Program classifications.*

(a) Maternal and child. Covers nursing services given during the antepartum and postpartum periods as well as services provided the infant up to 6 weeks of age. Because of the special considerations required, this category may be used for low birth weight infants, up to 1 year of age.

(b) Child abuse and neglect. Covers nursing services given to children suspected or confirmed as abused or neglected. This also covers preventive and therapeutic intervention services given other family members.

(c) Socio Econ. Covers services given to persons and families to determine need for referral to social economic resources.

(d) Handicapping conditions. Includes physical and/or mental impairment which reduces or precludes a person's actual or presumed ability to engage in gainful or normal activity permanently or over a prolonged period of time.

(e) Health promotion. Includes all nursing services to apparently well persons of all ages to guide them in practices to promote good health and prevent illness.

(f) Injuries. Refers to conditions resulting from accidents, poisoning, and violence.

(g) Mental health. Refers to services provided mentally ill persons and their families, as well as services provided to families whose major problem is considered emotional in nature.

(h) Disease control. Includes nursing intervention for treatment and control of disease and disability even though physical care is not given.

(3) *Clinic or class.* The number of times a clinic or class is held will be shown in the Sessions columns of section B. Show the number of persons attending the clinic or class in the Attendance columns of section B. When instructions and guidance are given on an individual basis before or after class or group conference, it is counted as a visit and recorded in section A, column e, per the definition of "visit" in AR 40–400. Record the number of immunizations given in the well baby/child clinic in the Attendance columns of section B.

(4) *Case load.* The number in column 26*b* refers to the total number of families for whom a family record has been opened. The number in the Patients column, section C, refers to the number of individuals in each family receiving nursing services.

(5) *Other program activities.* A Department of Army memorandum for chief, preventive medicine service, titled "Community Health Nursing Activities Report for (month) (year)" is generated as an accompanying narrative report and includes the DA Form 3761 as an enclosure of statistical workload data. This narrative memorandum includes program activities not reflected on the DA Form 3761 and provides an opportunity to expand on the meaning of the statistical data on the DA Form 3761. These other program activities include workload and issues related to program administration and management, quality assurance, staff development, consultation visits to installation activities (child development service facilities, schools, prisons, etc.), major program changes, staffing patterns, special projects, and other activities not recorded on the DA Form 3761. The narrative further provides an opportunity to do comparative analysis of program productivity and document resource needs.

d. Disposition. Destroy daily and weekly records when no longer needed. Monthly records will be kept for 2 years.

6–5. Workload Management System for Nursing (WMSN) automated reports

a. General. WMSN reports provide information on workload and nursing manpower resources based on patient acuity. This information is used by managers in workcenters, MTFs, major Army commands, Office of The Surgeon General, and Department of Defense. The patient acuity data is used to determine professional and paraprofessional manpower requirements for inpatient nursing units on an annual basis. FM 8–501 provides complete information on the WMSN automated system.

b. Specific reporting requirements.

(1) *Daily.* Inpatients are classified daily by an RN into the appropriate WMSN category. Based on acuity data and staffing schedules, the facility's projected workload, as well as required and available staff, are recorded and stored by the WMSN automated system. A variety of daily reports may be generated at the workcenter and facility level for local use.

(2) *Monthly.* Monthly summary data is transferred to a floppy disk and forwarded to headquarters. (See para 1–4*c*(2) for routing instructions.) The monthly WMSN report for each unit, or the WMSN Summary Report by Facility is to be maintained for 2 years. This information may be stored on a floppy disk or printed and kept on file.

Appendix A
References

Section I
Required Publications

AR 25–400–2
The Modern Army Recordkeeping System (MARKS). (Cited in paras 1–5, 4–1c, and 5–4g.)

AR 40–5
Preventive Medicine. (Cited in para 6–4a.)

AR 40–66
Medical Records and Quality Assurance Administration. (Cited in paras 2–1, 2–4b, 2–6 b, 2–15, 2–16, and 4–4a.)

AR 40–68
Quality Assurance Administration. (Cited in the summary of change and the summary.)

AR 40–400
Patient Administration. (Cited in paras 4–4a and 6–4a, c(1) and (3).)

DA Pam 40–5
Army Medical Department Standards of Nursing Practice. (Cited in para 2–7c(2) and (3).)

FM 8–501
The Workload Management System for Nursing. (Cited in paras 1–4c(2) and 6–5a.)

Section II
Related Publications

AR 11–2
Internal Control Systems.

DA Circular 11–89–1
Internal Control Review Checklists.

Section III
Prescribed Forms

DA Form 3760
Community Health Nursing—Family Index. (Prescribed in para 4–3.)

DA Form 3761 (RCS MED–371)
Community Health Nursing Activities. (Prescribed in para 6–4.)

DA Form 3762
Army Health Nursing—Family Record. (Prescribed in para 4–1.)

DA Form 3763
Community Health Nursing—Case Referral. (Prescribed in para 4–2.)

DA Form 3872
Nursing Service Personnel Time Schedule. (Prescribed in para 3–1.)

DA Form 3872–1–E (PCN: DXXXX–NAC–6G02)
Personnel Time Schedule. (Prescribed in para 3–1.)

DA Form 3887
Nursing Department—Army Nurse Corps Data. (Prescribed in para 3–5.)

DA Form 3888
Medical Record—Nursing History and Assessment. (Prescribed in para 2–6.)

DA Form 388–2
Medical Record—Nursing Care Plan. (Prescribed in para 2–7.)

DA Form 3888–3
Medical Record—Nursing Discharge Summary. (Prescribed in para 2–11.)

DA Form 3889
Nursing Unit 24–Hour Report. (Prescribed in para 3–2.)

DA Form 3889–1
Nursing Unit 24–Hour Report—Continuation Sheet. (Prescribed in para 3–2.)

DA Form 3950
Flowsheet for Vital Signs and other Parameters. (Prescribed in para 3–3.)

DA Form 3951
Nursing Service—Assignment Roster. (Prescribed in para 3–6.)

DA Form 4015
Nursing Care Assignment. (Prescribed in para 3–7.)

DA Form 4028
Prescribed Medication. (Prescribed in para 3–4.)

DA Form 4107
Operation Request and Worksheet. (Prescribed in para 5–2.)

DA Form 4108
Register of Operations. (Prescribed in para 5–4.)

DA Form 4677
Clinical Record—Therapeutic Documentation Care Plan (Non–Medication). (Prescribed in para 2–8.)

DA Form 4678
Clinical Record—Therapeutic Documentation Care Plan (Medications). (Prescribed in para 2–9.)

DA Form 4798–R (RCS MED–369)
Nursing Activities Report. (Prescribed in para 6–2.)

DA Form 4800–R (RCS MED–370)
Nurse Practitioner/Clinical Nurse Specialist Monthly Activities Report. (Prescribed in para 6–3.)

DA Form 5179
Medical Record—Preoperative/Postoperative Nursing Document. (Prescribed in para 5–5.)

DA Form 5179–1
Medical Record—Intraoperative Document. (Prescribed in para 5–6.)

DA Form 7001
Operating Room Schedule. (Prescribed in para 5–3.)

DA Form 7006–E (PCN: DXXX–NAC–6G01)
Personnel Time Schedule Worksheet. (Prescribed in para 3–1.)

DD Form 792
Twenty–Four Hour Patient Intake and Output Worksheet. (Prescribed in para 3–8.)

DD Form 1924
Surgical Checklist. (Prescribed in para 3–9.)

SF 510
Clinical Record—Nursing Notes. (Prescribed in para 2–10.)

Section IV
Referenced Forms

DA Forms 2789–R, –l–R, and –2–R (RCS MED–302)
Medical Summary Report (Sections I, II, and III) (AR 40–400).

DA Form 3444–series (1 to 9)
Alphabetical and Terminal Digit File for Treatment Record.

DA Form 4256
Clinical Record—Doctor's Orders.

DA Form 4700
Medical Record—Supplemental Medical Data.

SF 511
Clinical Record—Vital Signs Record.

SF 516
Medical Record—Operation Report.

SF 536
Clinical Record—Pediatric Nursing Notes.

SF 537
Medical Record—Pediatric Graphic Chart.

SF 539
Medical Record—Abbreviated Medical Record.

SF 600
Chronological Record of Medical Care.

Glossary

AMEDD
Army Medical Department

AN
Army Nurse Corps

AOC
area of concentration

ARNG
(U.S.) Army National Guard

cc
cubic centimeter

CNS
clinical nurse specialist

ESU
electrosurgical unit

expir
expiration

HR
health record (records filed in DA Form 3444 series folder)

IM
intramuscular

ITR
inpatient treatment record (records filed in DA Form 3444 series folder)

IV
intravenous

LPN
licensed practical nurse

mg
milligram(s)

MEDCEN
medical center

MEDDAC
Medical Department activity

MOS
military occupational specialty

MTF
medical treatment facility

NIO
nursing initiated order

NP
nurse practitioner

OB/GYN
obstetrics and gynecology

OR
operating room

OTR
outpatient treatment record (records filed in DA Form 3444 series folder)

PRN
pro re nata

q.
operation performed every; for example q.4H (operation performed every 4 hours)

RN
registered nurse

SF
standard form

SI
skill identifier

SOAP
subjective, objective, assessment, plan

SOAPIE
subjective, objective, assessment, plan, implementation, evaluation

USAR
U.S. Army Reserve

WMSN
Workload Management System for Nursing

Section II
Terms

This section contains no entries.

Section III
Special Abbreviations and Terms
This section contains no entries.

Index

This index is organized alphabetically by topic and by subtopic. Topics and subtopics are identified by paragraph number.

RESERVED

NURSING ACTIVITIES REPORT

For use of this form, see AR 40-407: the proponent agency is the OTSG.

RCS MED-369

Reporting Facility and Location (MEDCEN, MEDDAC)	Receiving Heqdquarters and Location (MACOM, OTSG)	Reporting Period (Day, Month, Year)
From:	To:	

SECTION A - NURSING STRENGTH (PROFESSIONAL)

Strength a.	AN Officers b.	Clinical Nurse Specialists c.	Nurse Practitioners d.	Primary AOC Breakdown									Civilian RNs			Total Strength Of Department q.
				66A e.	66B f.	66C g.	66D h.	66E i.	66F j.	66G k.	66H l.	66J m.	DAC n.	USFD o.	LN p.	
1 Required																
2 Authorized																
3 Assigned																

SECTION B - NURSING STRENGTH (PARA - PROFESSIONAL)

Strength a.	Enlisted Personnel b.	Primary MOS Breakdown							Unit/Ward Clerks		Nursing Assts			Civilian LPNs			Total Strength Of Department r.
		91A c.	91B d.	91C e.	91D f.	91F g.	91V h.	Other h.	Military j.	Civilian k.	DAC l.	USFD m.	LN n.	DAC o.	USFD p.	LN q.	
1 Required																	
2 Authorized																	
3 Assigned																	

SECTION C - AN OFFICERS NOT ASSIGNED TO DEPT OF NURSING

Nursing Methods Analyst

Community Health Nurse

Other

SECTION D - AN PROJECTED GAINS (Next 120 Days)

SECTION E - AN PROJECTED LOSSES (next 120 days)

DA FORM 4798-R, JUN 91

Previous edition is obsolete.

SECTION F - - REMARKS

Chief, Nursing Administration *(Name, Rank, Primary AOC)*

AN Promotions:

Chief Wardmaster *(Name, Rank, MOS)*

AOC/SI Changes:

Workload Information:

Bed Capacity:
  Avg Beds Occ: _____
  VSI *(Avg Daily)*: _____
  SI *(Avg Daily)*: _____

Deliveries: _____
  C-Sections: _____
  *Bassinetts Avail: _____
  Avg Daily Occ: _____
  *NICU Bassinetts Avail: _____
  Avg Daily Occ: _____
  NICU VSI *(Avg Daily)*: _____
  SI *(Avg Daily)*: _____

Episodes of OR Nursing:
  Elective Cases: _____
  Emergency Cases: _____
Anesthesia Episodes:
  General: _____
  Regional: _____
  Local: _____

Name Changes:

Actual Gains: *(Show name and actual date of arrival.)*

Actual Losses: *(Show name and actual date of departure.)*

Personnel Breakout:

Not assigned in Department of Nursing:
  Civilian RN: _____
  Enlisted and civilian paraprofessionals: _____
FTEs of contract/agency personnels
  RNs: _____
  Paraprofessionals: _____

TOE #: _____   Effec Date: _____
TDA #: _____   Effec Date: _____

Reverse of DA Form 4798-R   (If additional space is required, continue on plain bond paper and attach to this form.)

NURSE PRACTITIONER / CLINICAL NURSE SPECIALIST MONTHLY ACTIVITIES REPORT

For use of this form, see AR 40-407; the proponent agency is the OTSG

RCS MED-370

THRU: Chief, Department of Nursing

TO: Commander
U.S. Army Health Services Command
ATTN: HSCL-A / Ambulatory Care Nurse Administrator
Fort Sam Houston, TX 78234-6000

NAME:	RANK / GRADE:	SSI / ASI:	AUTOVON:

I. IDENTIFICATION
(Use codes and instructions on reverse)

Reporting Month		1
Year		2 - 3
MEDCEN / MEDDAC		4 - 5

Primary Area of Duty		6 - 7
Specialty		8 - 9

II. INDIVIDUAL PATIENT VISITS BY CATEGORY

ADULT NURSE PRACTITIONERS / MED-SURG / IC / ONCOL CNS

Chronic Illness	10 - 13
Acute Minor Illness	14 - 17
Health Counseling *(No Illness)*	18 - 21
Routine Physical Exams	22 - 25
Prescription Refill Only	26 - 29
Other	30 - 33
* TOTAL	34 - 37

PEDIATRIC NURSE PRACTITIONERS / CNS NEONATAL CNS

Newborn Care	10 - 13
Well Baby *(0 - 18 Months)*	14 - 17
Well Child	18 - 21
Acute Minor Illness *(All Ages)*	22 - 25
Prescription Refill Only	26 - 29
Other	30 - 33
* TOTAL	34 - 37

OB / GYN NURSE PRACTITIONERS

Prenatal	10 - 13
Postnatal	14 - 17
Routine Pelvic Exams	18 - 21
Gynecologic Problems	22 - 25
Prescription Refill Only	26 - 29
Other	30 - 33
* TOTAL	34 - 37

PSYCHIATRIC / MENTAL HEALTH NURSE PRACTITIONERS CNS

Emergency / Crisis	10 - 13
Assessment / Evaluation Only	14 - 17
Short Term Treatment (< 2 Mo.)	18 - 21
Long Term Treatment (> 2 Mo.)	22 - 25
Prescription Refill Only	26 - 29
Other	30 - 33
* TOTAL	34 - 37

FAMILY NURSE PRACTITIONERS

Acute Minor Illness (all ages)	10 - 13
Chronic Illness	14 - 17
Prenatal / Postnatal Care	18 - 21
Gynecologic Problems	22 - 25
Well Child / Infant Care	26 - 29
Physical Exams (all ages)	30 - 33
Prescription Refill Only	34 - 37
* TOTAL	38 - 41

* TOTAL PATIENT VISITS in Sec II must equal **TOTAL** in Section III

III. INDIVIDUAL PATIENT VISITS

Total Outpatients	42 - 45	No Shows	54 - 57
Total Inpatients	46 - 49	Cancel-	58 - 61
* TOTAL	50 - 53	lations	

* Breakdown of TOTAL:

Active Duty	Family Members	Retired
62 - 65	66 - 69	70 - 73

Prison Inmates	Allies	Trust Territory Beneficiaries
74 - 77	78 - 81	82 - 85

DAC	DAC Family Members	DAC Retired
86 - 89	90 - 93	94 - 97

IV. GROUP PATIENT ACTIVITIES

Total No. of Sessions		98 - 101
Total No. of Attendees		102 - 105

V. TIME DATA (Record in Hours)

HOURS
(1-9 See Sec 1)

Individual Patient Contact	110 - 112
Group Patient Contact	113 - 115
Staff Duty (Nursing Units)	116 - 118
Nursing Admin Duty (CNO)	119 - 121
Consultation	122 - 124
Educational Activities	125 - 127
Clinical Admin Time	128 - 130
Professional / Military Related Activities	131 - 133
Research / Special Projects	134 - 136
Other	137 - 139

VI. DUTY DAYS

DAYS

Days Off *(Incl holiday - trg holidays comp time)*	140 - 141
TDY *(Official and Permissive)*	142 - 143
Leave / Pass	144 - 145
Sick Leave *(Include Convalescent Leave)*	146 - 147
Maternity Leave	148 - 149
Work Days (Include In-processing)	150 - 151
** Total Days	152 - 153

** Should equal total days in Month

RECORD IDENTIFICATION	157 - 160

REMARKS: *(Use plain bond paper.)*

DA FORM 4800-R, JUN 91   Previous editions are obsolete.

IDENTIFICATION CODES

MEDCEN/MEDDAC

01	Brooke	19	Ft Dix	37	Ft Rucker
02	Eisenhower	20	Ft Eustis	38	Ft Sheridan
03	Fitzsimons	21	Ft Hood	39	Ft Sill
04	Letterman	22	Ft Huachuca	40	Ft Stewart
05	Madigan	23	Ft Irwin	41	Redstone Arsenal
06	Tripler	24	Ft Jackson	42	West Point
07	Walter Reed	25	Ft Knox	43	Augsberg
08	William Beaumont	26	Ft Leavenworth	44	Bad Cannstatt
09	Aberdeen Proving Ground	27	Ft Lee	45	Berlin
10	Alaska	28	Ft Leonard Wood	46	Bremerhaven
11	Carlisle Barracks	29	Ft McClellan	47	Frankfurt
12	Ft Belvoir	30	Ft McPherson	48	Heidelberg
13	Ft Benjamin Harrison	31	Ft Meade	49	Landstuhl
14	Ft Benning	32	Ft Meyer	50	Nuernberg
15	Ft Bragg	33	Ft Monmouth	51	Wuerzburg
16	Ft Campbell	34	Ft Ord	52	Shape
17	Ft Carson	35	Ft Polk	53	Korea
18	Ft Devens	36	Ft Riley	54	Japan
				55	Vicenza

PRIMARY AREA OF DUTY

01 Inpatient Setting
02 Outpatient Clinic *(within hospital)*
03 Freestanding Clinic/Army Health Clinic
04 Troop Medical Clinic
05 Mental Hygiene Clinic
06 Army Drug and Alcohol Program
07 Other

PRACTICE CODE

01 Ambulatory Care Nurse Practitioner
02 OB/GYN Nurse Practitioner
03 Pediatric Nurse Practitioner
04 Psyc/Mental Health Nurse Practitioner
05 Family Nurse Practitioner
06 Med/Surg Clinical Nurse Specialist
07 Neonatal Clinical Nurse Specialist
08 Pediatric Clinical Nurse Specialist
09 Psyc/Mental Health Clinical Nurse Specialist
10 Intensive Care Clinical Care Specialist
11 Oncology Clinical Nurse Specialist

SPECIAL INSTRUCTIONS

GENERAL: Use only the options provided on the form itself. Do not write in additional information except in the REMARKS section. NP complete all sections. CNS complete all sections except Section II.

SECTION I: Use only the codes listed above. Choose one area of duty and one specialty code that most closely describes your role. If you have specialized knowledge, title, etc., still choose code from above and explain difference in REMARKS.

SECTION II: To be completed by Nurse Practitioners only. Use only the subgroup of patient categories that corresponds to your clinical practice. (Family Nurse Practitioners - give only totals in each of the four categories.) Totals in Section II should equal total in Section III.

SECTION III: If telephone consults or inpatient visits are recorded on the patient's cart, record as a "visit". Count each patient only once in each category.

SECTION IV: Include all group contacts other than those with other professional persons, i.e., group therapy, patient education groups, etc. Do not count patients seen in group as individual contacts.

SECTION V: Round off all figures to nearest hour.
Consultation - Time spent on rounds, consultation with other professionals, patient care conferences / discharge planning, etc.

Educational Activities - Includes inservice / CEU presentations and attendance.

Research - Literature review / data collection, clinical trials / research projects, project development / coordination

Clinical Admin. Time - Includes time spent reviewing lab work, X-rays, etc., making phone calls, making schedules

Professional / Military Related Activities - includes in-processing, APFT, Boards, Dental / Medical appointments, writing for publications, peer review activities, OER Support Form counseling

SECTION VI: Round off all figures to the nearest whole day.

USAPA

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