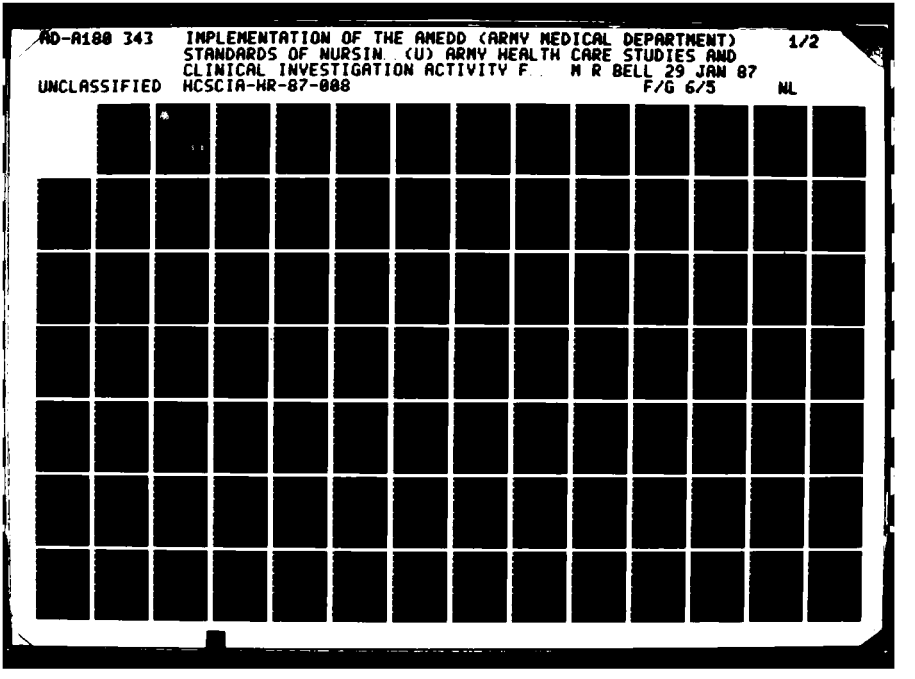
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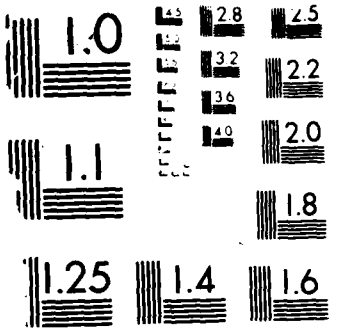

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United States Army Health Care Studies and Clinical Investigation Activity

IMPLEMENTATION OF THE
AMEDD STANDARDS OF NURSING PRACTICE:
AN EVALUATION

FINAL REPORT

LTC Martha R. Bell, AN

Report #HR 87-008

January 1987

US ARMY
HEALTH SERVICES COMMAND
FORT SAM HOUSTON, TEXAS 78234

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ERRATA SHEET

IMPLEMENTATION OF THE AMEDD STANDARDS OF NURSING PRACTICE:
AN EVALUATION

NOTE a: Corrections to be made to cited text portions are underlined.

NOTE b: Materials provided in the Annexes to Appendix D are examples of references which could be used when developing MTF specific programs to address implementation issues. They are not to be construed as official AMEDD/DA policies.

PAGE	CORRECTION
ii, Para 19 line 7	" ...Officers' Advanced Course (OAC)..."
iii, line 3	"...revision of the OAC students' document..."
9, Para 5b, line 3	"...proponency at OTSG Quality..."
10	"Donabedian, A. (1972)..."
B-3, References, Risser, line 3	"...nursing care in..."
D-39, para 3 line 1	"...each patient receives a copy..."
D-51, Guidelines for Implementation para 2, line 2	"...is made available to nursing personnel for attendance at such offerings."
D-52, Guidelines for Evaluation para 1, line 4	"...at the unit and in a..."
D-56 thru D-61	when specifically referenced throughout these pages, the title "Nursing QA Committee" should be capitalized.
D-66, Annex M-1	"Sample Performance Standards:..."
D-66, Annex M-2	"Sample Performance Standards:..."
D-66, Annex M-3	"Sample Performance Standards:..."
D-67, M-1	"Sample Performance Standards:..."
D-67, M-2	"Sample Performance Standards:..."
D-67, M-3	"Sample Performance Standards:..."

ERRATA SHEET (continued).

PAGE	CORRECTION
D-84, para 2e, line 1	"STAT situations. The nurse..."
D-84, para 2f, line 3	"...by the prescriber within..."
D-88, para 7b, line 2	"...and the copy is reviewed..."
D-95, question 19, line 1	"...the use of CaCl?"
D-110 thru D-115	Title on all pages should read: "SAMPLE"
D-116 thru D-125	Title on all pages should read: "SAMPLE PERFORMANCE STANDARDS: CLINICAL HEAD NURSE"
D-117, para B, subpara, b, line 1	"...exist, the HN will..."
D-118, para b, subpara f line 9	"...the ANC, the JCAH, and..."
D-121, para c, subpara h, line 3	"...and the nursing supervisor STAT."
D-126 thru D-133	Title on all pages should read: "SAMPLE PERFORMANCE STANDARDS: CLINICAL STAFF NURSE"
D-129, para c, subpara b line 4	"...supervisor STAT."
D-134 thru D-137	Title on all pages should read: "SAMPLE PERFORMANCE STANDARDS: 91C/LICENSED PRACTICAL NURSE (LPN)"

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Study was assigned as part of the FY 85 AMEDD Study Program and reviewed evaluation and implementation efforts of the AMEDD Standards of Nursing Practice (SONP) between 1978 and 1985. Of significance was the 1983 work completed by a task force of ANC officers at West Point, NY which surveyed 40 Army medical treatment facilities and identified impediments to the efficient and effective implementation of the standards of nursing practice, among which was the need for a standard audit tool between facilities. ANC students in the AMEDD Officers' Advanced Course used the West Point findings to develop a method for evaluating compliance with the standards. The document provided operational definitions, guidelines for implementation and evaluation of the Army SONP, and suggested areas of responsibility at individual, facility, and command levels. A copy of their document, in addition to abstracts of two independent efforts to evaluate the impact of the standards on patient and staff satisfaction was included in this report. The OAC students' document is a first initiative to develop evaluation methods for the practice standards. It also stands as a

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preliminary effort to provide a collection of references for individual facilities to use when developing local programs addressing implementation issues. RECOMMENDATIONS: 1) review and revision of the AOC students' document by nursing representatives within OTSG and HQ HSC quality assurance and consultant offices; 2) publication, in the most appropriate format, of the implementation/evaluation plan with proponency at DA Quality Assurance level; and 3) evaluation of MTF progress based on newly published guidelines.

SUMMARY

Professional standards of nursing practice (SONP) provide the framework for nurses to assure quality service to the public. In 1978, the US Army Nurse Corps (ANC) published their own standards of practice, based upon the American Nurses' Association (ANA) practice standards. The Army Medical Department's (AMEDD) standards established minimal acceptable levels of professional nursing practice within the ANC. The standards were also perceived as a tool to evaluate nursing care and were implemented world-wide between 1979 and 1981. Evaluation of the SONP implementation was deemed appropriate to identify the status of implementation efforts and to identify problem areas hampering full implementation. This study reviewed evaluation and implementation efforts to date. The study findings have implications for quality assurance monitoring of nursing care in the AMEDD.

Several early efforts to assess the impact of SONP implementation on patient and staff satisfaction were identified, but their findings precluded causal relationships and generalization of results because of methodological limitations. However, in 1983 a task force of ANC officers at Keller US Army Community Hospital, West Point, New York surveyed 40 Army medical facilities throughout the US Army Health Services Command (HSC) and the 18th Medical Command in Korea. The task force concluded that although the SONP had been implemented at all facilities "to varying degrees", efficient and effective implementation was impeded by the variation in the availability of local resources and the cumbersome nature of the nursing documentation system. Various facility-specific methods and evaluation tools used for implementation had contributed to fragmented efforts. Among the task force's recommendations were the development of a standard audit tool designed to measure the degree of implementation between and among facilities, and the consolidation of nursing forms to facilitate a more manageable system.

Another study effort has addressed the forms issue, but development of methods for evaluating compliance with the standards was addressed as an independent study by ANC students in an AMEDD Officers' Advanced Course (OAC). Their document provides operational definitions, guidelines for implementation and evaluation of the Army standards of nursing practice,

and suggests areas of responsibility at individual, facility, and command levels.

While comprehensive in scope, the OAC student's draft proposes specific actions and outcomes requiring compliance that may prove too restrictive for local levels. It is a first initiative to develop such evaluation methods, and stands as a preliminary effort to provide a collection of references for individual facilities to use when developing local programs involving the standards of practice. If the ANC desires a standardized document to facilitate measurement of the implementation process, the draft is worthy of review, revision, and dissemination from Office of The Surgeon General (OTSG) quality assurance levels.

TABLE OF CONTENTS

TABLE OF CONTENTS (Continued)

LIST OF FIGURES

ACKNOWLEDGEMENTS

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GLOSSARY

AMEDD - Army Medical Department

ANA - American Nurses Association

ANC - Army Nurse Corps

AR - Army Regulation

AHS - Academy of Health Sciences, Fort Sam Houston, Texas

CCU - Cardiac Care Unit

CEU - Continuing Education Unit

CN - Chief Nurse

CNO - Chief Nurse's Office

CPR - Cardiopulmonary Resusitation

DA - Department of the Army

DON - Department of Nursing

DNAP - Department of Nursing Administrative Policy

HCSCIA - US Army Health Care Studies and Clinical Investigation Activity, Fort Sam Houston, Texas

HSC - United States Army Health Services Command, Fort Sam Houston, Texas

IAW - In Accordance With

ICU - Intensive Care Unit

IG - Inspector General

JCAH - Joint Commission on Accreditation of Hospitals

LPN - Licensed Practical Nurse

MEDDAC - Medical Department Activities

MTF - Medical Treatment Facility

GLOSSARY (Continued)

NESD/(NETS) - Nursing Education and Staff Development (formerly known as Nursing Education and Training Section, abbreviated: NETS)

NMA - Nurse Methods Analyst

OAC - Officers' Advanced Course

OBC - Officers' Basic Course

OER - Officer's Efficiency Report

OTSG - Office of The Surgeon General

PAM - Pamphlet

QA - Quality Assurance

RN - Registered Nurse

SF - Standard Form

S/O - Significant Other

SOAPIE - Subjective/Objective/Assessment/Plan/Intervention/Evaluation (a format for nursing documentation)

SONP - Standards of Nursing Practice

SOP - Standard Operating Procedure

TDY - Temporary Duty

USA - United States Army

VT - Video Tape

WEF - Ward Eduction Facilitator

THE IMPLEMENTATION OF THE ARMY MEDICAL DEPARTMENT'S STANDARDS OF NURSING PRACTICE: AN EVALUATION

1. INTRODUCTION

a. **Background.** Society gives professionals the right to manage their own functions. In turn, through either an implicit or explicit understanding, the professions are responsible to society for their actions. Because of this "contract" professionals must insure the quality of provided service (Donabedian, 1972). For nurses, recognition of their responsibility to the public is manifest in the professional standards of practice with their overarching purpose being to assure high quality service to the public.

In 1966, the American Nurse's Association (ANA) espoused the need to delineate minimal acceptable standards of nursing practice (SONP). Subsequently, in 1973, the ANA published standards developed by its Divisions on Nursing Practice; the standards, more philosophical than operational, being viewed as descriptive statements of the dynamic nature of nursing practice. The underlying premise stated was: "the individual nurse is responsible and accountable..." (ANA, 1975, p.2) for the quality of nursing care. At the time of their publication, the standards were conceptualized as working documents providing the foundation for the profession's self-monitoring (M. Phaneuf, M. Wandelt, 1974). The next step was the development and use of practice evaluation methods based on the established standards (Phaneuf and Wandelt, 1974).

Like their civilian counterparts, nurses in the US Army Nurse Corps (ANC) have a responsibility to insure the quality of service provided. To fulfill the profession's recognized obligation to assess, provide, evaluate, and improve nursing practice within the Army, in 1978 the ANC published their own practice standards. The standards established minimal levels of professional nursing practice within the ANC. Furthermore, they were perceived to be a tool to evaluate nursing care (Johnson, 1979).

The initial 13 Army Medical Department (AMEDD) SONP were based on the ANA standards (ANA, 1973), and were considered applicable to all nursing specialties. Like the ANA, the ANC viewed the standards as dynamic and subject to refinement. The SONP were in fact revised in Department of the Army (DA) Pamphlet (Pam) 40-5, Army Medical Department Standards of Nursing Practice (November, 1981). They are:

- STANDARD I, COLLECTION OF DATA
- STANDARD II, NURSING CARE PROBLEMS
- STANDARD III, NURSING CARE GOALS
- STANDARD IV, NURSING CARE PLAN
- STANDARD V, NURSING ACTION
- STANDARD VI, IMPLEMENTED CARE PLAN
- STANDARD VII, REASSESSMENT OF PATIENT PROGRESS
- STANDARD VIII, PATIENT'S INDIVIDUAL RIGHTS
- STANDARD IX, CLINICAL NURSING RESEARCH
- STANDARD X, CARDIOPULMONARY RESUSCITATION COMPETENCY
- STANDARD XI, CONTINUING EDUCATION
- STANDARD XII, QUALITY ASSURANCE
- STANDARD XIII, PROFESSIONAL GROWTH (DA Pam 40-5, 1981, p. i)

Building on the original 13 standards, ANC officers in community and occupational health have published standards more specific to their clinical domains. Other ANC nursing specialty groups, to include psychiatry, operating room, and obstetrics/gynecology, are in the process of drafting standards appropriate for their clinical areas.

By 1984, ANC leaders asked: "Have the standards made a difference?" Intuitively, impressions were affirmative. However, there was a desire for more objective and quantifiable data; therefore, when the

ANC Nursing Research Advisory Board (NRAB) convened to recommend study topics for inclusion in the Fiscal Year 1985 (FY 85) AMEDD Study Program, evaluation of the SONP implementation was a high priority issue.

However, the NRAB also recognized that their question necessitated an experimental design, including a pretest, random selection and control group. Such a design could not be used with the AMEDD SONP because the 1979 world-wide implementation had not been accomplished with the three experimental design criteria in mind. Therefore, the Chief of the ANC directed the United States Army Health Care Studies and Clinical Investigation Activity (HCSCIA), as part of the FY 85 AMEDD Study Program, to evaluate the implementation status of the SONP in a posttest only manner.

b. Purpose/Objectives. Two study purposes emerged: 1) assess the implementation status of the SONP throughout the AMEDD; and 2) identify problem areas hampering full implementation.

During proposal development, prior evaluation efforts to assess the status of implementation were identified (Appendix A). Chronologically, several of the efforts had overlapped without evidence of coordination. In spite of this, it became obvious that the study purposes had been addressed. Thus, the purpose of the present HCSCIA evaluation effort changed to become a review of previous evaluation and implementation efforts.

2. METHODOLOGY

a. Data Collection. Primary sources for data included files of the Nursing Consultant to The Office of the Surgeon General (OTSG), and files of the Nursing Division, Headquarters, United States Army Health Services Command (HSC). In addition, attendees at the 1984 Drusilla Poole Nursing Education and Training Conference participated in discussion groups which provided insights regarding implementation of standards. A final method involved interviews conducted with principal investigators of the studies cited in this document, and with nurse members of the HSC Inspector General (IG) survey team, and nurse quality assurance (QA) consultants at OTSG and HSC.

3. RESULTS

The following section summarizes standard implementation efforts cited in Appendix A.

a. Implementation Measures at Selected Army Facilities. Early in the standards' implementation phase, ANC officers at two Army medical treatment facilities (Kimbrough Army Community Hospital, Fort Meade, MD and DeWitt Army Community Hospital, Fort Belvoir, VA) completed studies designed to describe the effects of implementation at selected Army facilities (Carson, Smith, Sadler, & Weathington, 1980; Robinson, 1980). Abstracts of these reports prepared during the current study are Appendices B and C.

In summary, Carson et al. (1980) measured patient and staff satisfaction with nursing care, in addition to patient perceptions of the quality of care; Robinson (1980) measured only patient satisfaction. Both concluded that higher levels of patient satisfaction followed SONP implementation. Carson et al. also concluded a higher degree of staff satisfaction followed implementation. However, investigators of both studies were unable to state correlations because of weak study designs. All investigators identified methodological limitations of their respective studies which precluded causal relationships and generalization of results. Threats to internal validity of the post- test only designs included intervening variables, convenience sampling, study assumptions, and the absence of tool reliability testing.

b. Assessment of SONP Implementation Status. At the request of the Chief of the Army Nurse Corps, a task force of ANC officers at Keller US Army Community Hospital, West Point, New York, was formed in May 1983, to determine the status of SONP implementation throughout HSC and the 18th Medical Command in Korea. Information was solicited from 40 medical treatment facility (MTF) chief nurses. Content analysis of the data from the responding 39 facilities included:

1) the methods used by each hospital to implement and/or plan the approach towards implementation of the standards;

2) the criteria each facility employed to measure the degree and/or success of implementation; and

3) the identification of those standards implemented at each facility (Department of Nursing Task Force, West Point, 1983).

The task force concluded that the SONP had been implemented to "varying degrees" at every medical treatment facility: "...within the first year (after) introduction...a significant number of MTFs began a major thrust towards implementing..." (Department of Nursing Task Force, West Point, 1983, p. 5). Based upon the self-reporting from the MTFs, the investigators concluded that: a) SONP implementation was "well on (its) way to becoming a completed action..." (p. 8); and b) the standards appeared to have increased nurses' awareness regarding the necessity for the nursing process and improved documentation.

An objective assessment of the methods and the degree of implementation was problematic for task force members due to the "open-ended" reporting format. However, the primary method identified to implement Standards I through VII was formal staff education (including hospital, unit, and ward inservice offerings, workshops, temporary duty (TDYs), lectures, and classroom presentations). The remaining six standards were implemented using committees.

Impediments to efficient and effective SONP implementation were attributed to the variation in availability of local resources and the cumbersome nature of the nursing documentation system. Quality of implementation efforts appeared to be correlated with the resources available at each institution. For example, facilities with a full-time quality assurance nurse reported a more complete degree of implementation (Department of Nursing Task Force, West Point, 1983). The West Point task force concluded that the various facility-specific methods and evaluation tools used for SONP implementation had contributed to fragmented implementation and assessment efforts.

The task force recommended:

1) development of a standard audit tool designed to measure the degree of

implementation throughout HSC;

2) recognition of a QA nurse position at each facility;

3) consolidation of nursing forms to facilitate a more manageable system;

4) development of a programmed text, to include the nursing process and nursing physical assessment skills; and

5) inclusion of the standards as a priority criterion in all performance appraisals.

c. 1984: Release of the West Point Results; the ANC Strategic Planning Meeting; AMEDD Officer's Advanced Course Students' Project. The results of the West Point Task Force were released to chief nurses by the OTSG Nursing Consultant who indicated that all standards, with the exception of research, had been implemented in varying degrees at all MTFs (McLeod, 1984). Areas needing improvement included the need to:

- monitor patient outcomes and outcome criteria more closely;

- reevaluate nursing care plans in a more timely fashion;

- improve evidence of discharge planning; and

- increase the number and quality of nursing orders (McLeod, 1984).

Several taskings were made based upon the West Point results and recommendations from the 1984 ANC Strategic Planning Meeting: AMEDD chief nurses were to provide semi-annual implementation status reports to major command chief nurses; and OTSG nursing QA representatives were to develop a methodology to evaluate the degree of compliance with the nursing practice standards (Slewitzke, 1985).

Concomitantly, but independent of the QA tasking, three ANC officers in an AMEDD Officers Advanced Course

(OAC) chose to use the West Point findings as the basis for an independent study designed to develop methods for evaluating compliance with the standards (D. Dultgen, K. Driggers, P. Kanner, 1984). The document (Appendix D) emphasized the need for operational definitions; outlined guidelines for the implementation and evaluation of each of the original 13 standards; and suggested areas of responsibility at individual, facility, and command levels.

d. Other Efforts Regarding Standard Implementation Issues. In addition to chief nurses' semi-annual implementation status reports, other "status reports" are completed approximately every 20 months by the HSC IG staff using the SONP as a criterion for their evaluation. Current IG nurses believe the implementation of the SONP is a "fait accompli", stressing, however, that the quality of the implementation varies among facilities. A review of recent IG and Joint Commission on Accreditation of Hospitals (JCAH) findings noted comments regarding areas of implementation difficulties similiar to those previously cited by the OTSG consultant (McLeod, 1984).

Independent efforts, some on a local MTF level, others more global in nature, have been designed to address implementation impediments. In 1984, following an annual IG survey, ANC officers in Nursing Education and Training Service, Quality Assurance, and the Nursing Research Service at Walter Reed Army Medical Center conducted an intensive review of nursing process problems at that facility (McMarlin and Fiske, 1984). The program undertaken addressed problem areas to include classes on the nursing process and change theory. The Walter Reed study recommended department-wide goals, emphasizing a need for top level management support of the nursing process. Nursing personnel at Forts Dix, Belvoir, Lee and West Point had initiated similiar efforts resulting in commendations from inspection teams.

From a broader perspective, the Clinical Nursing Records Study, (Bell, Misener, and Twist, 1985) was designed to field test revised nursing documentation forms. Based on comments received from nursing personnel world-wide, tested form revisions and regulatory changes proposed to enhance continuity of the inpatient record by reducing redundancy and fragmentation of

nursing documentation.

4. Discussion and Summary

While early efforts to evaluate standard implementation impact on patient and staff satisfaction were hindered by methodological limitations, they provided valuable experiences which further strengthened Pfaneuf and Wandelt's (1974) position that the profession had to "develop and utilize methods that can be applied in evaluating actual practice in terms of the established standards..." (p. 331). Nurses in Army health facilities continued to address the issue of implementation in an unstructured fashion largely due to the varied resources available at facilities. Individual MTF staffs were forced to devise programs to address identified standard compliance problems not "apriori", but "ex post facto". Army-wide, nurses were hindered by the lack of a uniform method to evaluate practice in terms of the standards.

The document drafted by the ANC OAC students is, in essence, the first initiative to develop a methodology to evaluate the degree of compliance with the professional standards of nursing practice in the ANC. In addition, the work stands as a preliminary effort to provide a collection of references for individual facilities to use when developing programs to address local issues.

Yet, while comprehensive in scope, the OAC students' draft proposes very specific actions and expected outcomes with which MTFs and staff levels would be required to comply. In its specificity, it may preclude flexibility for facilities to devise their own progams. Any document, if directive, rather than facilitative in scope, restricts some creativity at the local level.

The ANC had taken a major step with the establishment of practice standards at a time when the nursing profession was moving forward in its public responsibilities. The next step, as articulated by Pfaneuf and Wandelt, is to develop methods necessary for evaluating practice in terms of the standards. The development of the ANC standards was centrally coordinated; the development of methods to evaluate practice in those terms must also be a coordinated

effort. Isolated pockets of work, regardless of how worthy the purpose, dedication of personnel, and strength of design, will not receive the attention, nor carry the regulatory strength that such a coordinated effort would produce.

If the Army Nurse Corps desires a standardized document to facilitate the implementation process, the OAC students' document has the potential to provide baseline criteria for measurement of progress within and among local activities. It requires review, revision, approval and dissemination from OTSG quality assurance levels. These are not easy activities, yet they are ones which would prove invaluable to Army nursing.

5. Recommendations

In concert with the ANC Strategic Planning tasking, the following are recommended:

a) review and revision of Appendix D by nursing representatives within OTSG and HQ HSC quality assurance and consultant offices;

b) publication, in the most appropriate format, of the implementation/evaluation plan with proponency at DA Quality Assurance level;

c) evaluation of MTF progress based on newly published guidelines.

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APPENDIX A

FIGURES

Figure 1. Time-line of Efforts Regarding the Implementation/Evaluation of the AMEDD Standards of Nursing Practice.

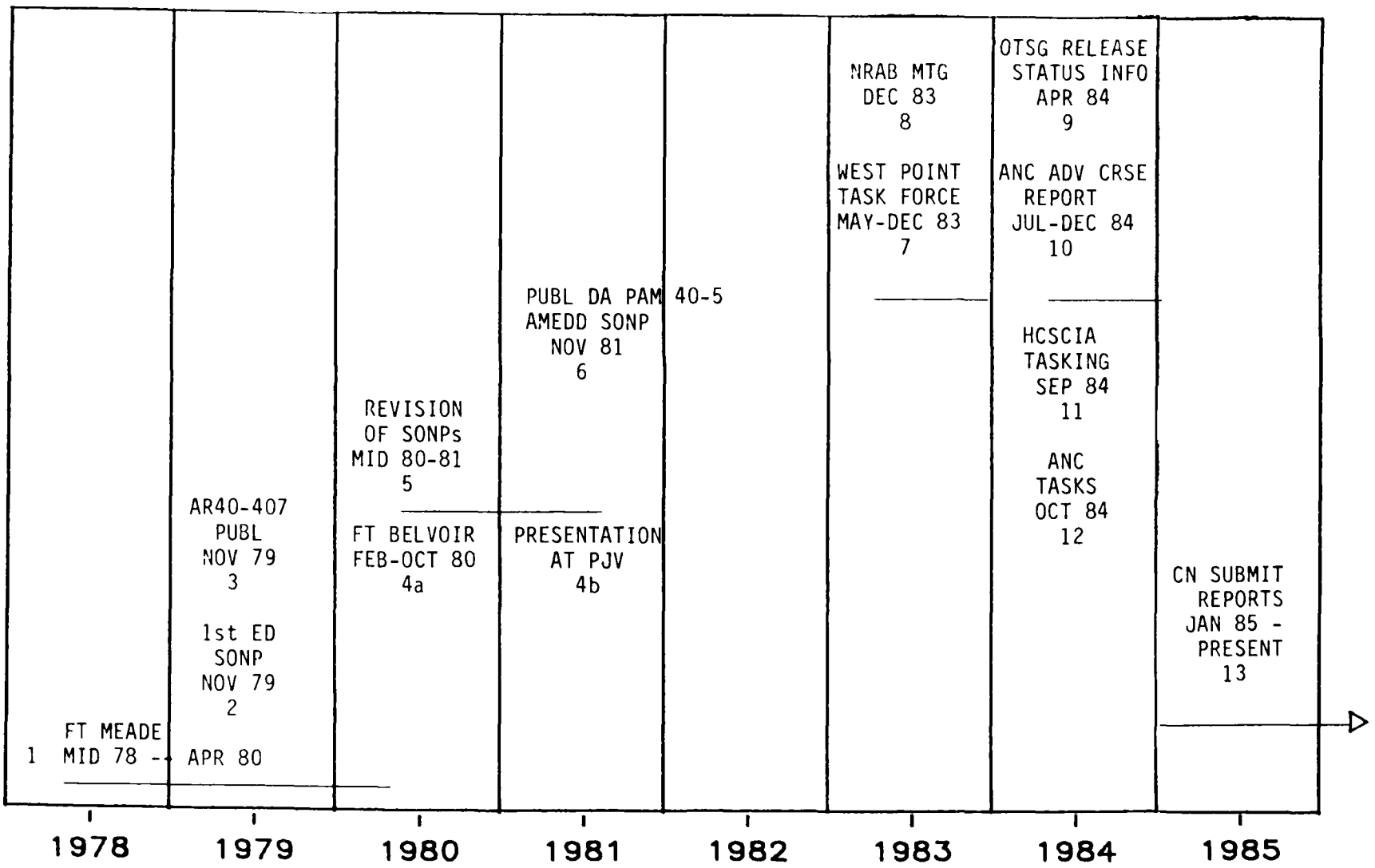

Figure 1. Legend

1. Mid-November 1978 (approx) - April 1980.
Development of nursing practice standards and a study to evaluate their effects on patient and staff satisfaction, Kimbrough US Army Community Hospital, Fort Meade, MD.

2. November, 1979.
Publication of the 1st edition of the SONP.

3. 1 November 1979.
Publication of AR 40-407, Nursing Records and Reports, describing use of new nursing forms to document elements of the nursing process as mandated by the SONP.

4a. February - October 1980.
Study entitled "Patient Satisfaction: An Indicator of Change After Implementation of a Nursing Care Standards Program", conducted at DeWitt US Army Community Hospital, Fort Belvoir, VA.

4b. July 1981.
Presentation of previously cited study at the 1st Annual Phyllis J. Verhonic Nursing Research symposium.

5. Mid 1980 - 1981 (approx).
Revision of the 1st edition of the SONP.

6. November 1981.
Publication of DA Pam 40-5, AMEDD Standards of Nursing Practice.

7. May - December 1983.
Keller US Army Community Hospital, US Military Academy, West Point, NY Task Force work regarding the status of standard implementation.

8. December 1983.
ANC Nursing Research Advisory Board rcommends the status of implementation be studied as part of the FY 83 AMEDD Study Program.

9. April 1984.
OTSG Nursing Consultant's release of West Point Task Force results regarding the degree of SONP implementation and methods used for implementation.

Figure 1. Legend (Continued).

10. July - December 1984.
Independent Study Project by ANC officers in the AMEDD Officers' Advanced Course designed to address implementation problems cited in the West Point report.

11. September 1984.
Assignment of the study to the USA Health Care Studies & Clinical Investigation Activity, FY 1985.

12. October 1984.
Tasking as a result of the September 1984 ANC Strategic Planning Meeting: Task #4 "Appoint task force of QA nurses to review field recommendations and develop implementation/evaluation plan"; Task #52 "Provide standard implementation status reports to Chief Nurse, MACOM".

13. January 1985.
Biannual status reports submitted in accordance with Task 52.

APPENDIX B

ABSTRACT

EVALUATION OF THE EFFECTS OF NURSING PRACTICE STANDARDS ON PATIENT AND STAFF SATISFACTION

Kimbrough US Army Community Hospital
Fort George G. Meade, MD
1980

LTC Amelia J. Carson, ANC
MAJ Mary E. Smith, ANC
CPT Freida J. Sadler, ANC
CPT Elizabeth A. Weathington, ANC

In 1978, the nursing staff at Kimbrough US Army Community Hospital (KACH) developed and implemented a set of SONP using the American Nursing Association's standards of practice as an organizational framework. (With minor modification, the KACH standards would eventually become the first eight AMEDD Standards of Nursing Practice.) Following a year's implementation, the staff noted there had been a dramatic decrease in the number of patient complaints; at the same time, positive comments in the forms of letters of appreciation, thank you cards, small tokens of appreciation from patients (candy, flowers, etc.) had increased 100%. A short questionnaire issued to 30% of the nursing staff evaluated job satisfaction and quality of patient care in relation to the SONP. Ninety percent of the respondents "favorably answered" the questionnaires (Carson, et al., 1980, p. 1).

A followup, two phase, descriptive study was conducted by the nursing staff to measure "quality of patient care, and the patient and staff satisfaction that was sensed following standards' implementation" (Carson, et al., 1980, p.9). Since operationalized measurements were not taken prior to implementation, the investigators realized that a "before and after" comparison of the quality of nursing care was not possible. Therefore, it was decided to compare the quality of care at four Army hospitals in various stages of standard implementation. The hypothesis was that the full implementation of the SONP would improve the quality of nursing care, employee, and patient satisfaction.

Four Army MTFs on the east coast were involved in the study. One had developed a set of SONP in 1978 and had presented inservices on the nursing process, the nursing documentation format of Subjective/Objective/Assessment/Implementation/Evaluation (SOAPIE), primary nursing, and physical assessment prior to implementation of the standards. The other three were in various stages of implementing the first edition of the ANC SONP. Two of these hospitals utilized a functional type approach to the delivery of care on all nursing units. The third had fully implemented primary nursing on the Intensive Care Unit (ICU)/Cardiac Care Unit (CCU), with other nursing units in various stages of implementing primary care.

The Risser Patient Satisfaction Scale (Risser,

1978) was used to measure patients' attitudes toward nurses and nursing care. A modified Measurement of Work Satisfaction among Health Professionals Instrument (Stamps, et al., 1978) was used to measure the level of staff satisfaction. The investigators believed that job satisfaction would increase if the care providers were more satisfied with the manner and method of providing that care, and if criteria were established for attaining quality. In addition to increased job satisfaction, it was also believed that patient satisfaction would improve after standard implementation. The Quality Patient Care Scale (Wandelt and Ager, 1974) was used to conduct patient observations in the clinical settings.

While patient perceptions and "quality" of administered care are often difficult to precisely measure, Carson, et al. (1980) reported: ". . .in hospitals where standards were implemented and possibly where a concept of primary care was an integral part of those standards. . ." (p. 16) patients cited that individualized care was the most outstanding factor that provided them with security and satisfaction. In the hospitals with standards not fully implemented, the patients found it difficult to identify specific components which met their needs. The data also suggested that patient and staff satisfaction were higher in the hospitals which had implemented the SONP than in hospitals which were in the initial implementation stage. However, the investigators made a final statement: "In the final analysis, patients felt that if their basic needs were met, they had received the best care possible, no matter who provided it. . ." (Carson, et al., p. 15, 1980).

Four recommendations were made: a) continued emphasis of the standards in all Army MTFs; b) replication of the study in participating facilities at a later date; c) development of formalized staff development programs concerning assessment, the nursing process, and standard explanation; d) continued opportunities for patients to evaluate their care.

Major limitations in this research effort were the varied educational emphasis and use of different nursing care delivery concepts (e.g., functional versus primary care) between facilities, and the previously stated problems with measuring perceptions and quality.

The study report was submitted to the Chief, ANC; copies were provided to the ANC Historian and Chief, Nursing Research Service, Walter Reed Army Medical Center.

References:

Risser, Nancy L. (1978). Development of an instrument to measure patient satisfaction with nurses and Nursing care in primary care settings. Nursing Research (2): 114-120.

Stamps, Paula, et al. (1978). Measurement of work satisfaction among health professionals. Medical Care 16(4): 377-352.

Wandelt, M.A., Ager, J. (1974). Quality patient care scale. New York: Appleton-Century-Crofts, 1974.

Appendix C

ABSTRACT

PATIENT SATISFACTION:
AN INDICATOR OF CHANGE AFTER IMPLEMENTATION
OF A NURSING CARE STANDARDS PROGRAM

MAJ Marylou V. Robinson, ANC

During late 1979, personnel in the Department of Nursing, DeWitt US Army Hospital, Ft Belvoir, VA, developed a program to introduce the SONP and related nursing documentation requirements for nursing personnel. At the same time, in an unrelated move, the chief nurse expressed a desire to conduct an informal satisfaction survey of the inpatients. While adapting opinion forms used by civilian institutions, the Chief, Nursing Education and Training, identified a link between items on the survey forms and the AMEDD SONP. Combining the two projects, a descriptive study was done "to monitor patient satisfaction levels in response to the implementation of a nursing care standards program" (Robinson, 1980, p. 3).

It was hypothesized that there would be a positive correlation between implementation of a standards program and hospital average measured satisfaction levels. A second hypothesis stated: implementation of a specific program to meet standard goals would also "significantly increase post-test ward general satisfaction levels...and post-test item scores from pre-test levels" (Robinson, 1980, p. 5).

Assumptions made were: patient opinions expressed as a satisfaction level only reflected the perception of personal expectations and needs met by the nursing staff; the investigator developed survey questionnaire based on the SONP was valid and reliable in measuring patient satisfaction (a review of the questionnaire by 25 staff members provided content validity; no reliability data was reported); satisfaction toward life, society, and the military was, in general, evenly distributed throughout the population, and therefore, would not affect the results; and services reported were given.

Two convenience sample groups of fifty patients each (from all but intensive care inpatient units) were invited to complete a survey questionnaire. One group completed the questionnaire prior to initiation of the nursing standards program for Department of Nursing personnel; the second group completed the questionnaire following program initiation. Other data collected by the investigator included the ward specialty, average daily census, staffing ratios, workloads, and patient characteristics such as gender, age, and length of hospitalization.

A decrease in staffing occurred during the time the post survey group was hospitalized. However, Robinson (1980) reported increases in the average hospital raw satisfaction score (from 30.3 to 34.5 points out of a possible 40 points), and the average satisfaction scores of all participating nursing units (between 1.0 to 7.4 points). In addition, average scores per item were reported to have increased above baseline scores; the greatest gains were reported in patient participation in the planning of care (supporting data not available in report). Robinson (1980) concluded: "the trends in this study support the conclusion that the patients not only perceived a change (alterations in hospital, unit, and item scores) but were more satisfied as a result of those changes (increases in all unit and item scores)."

The assumptions of the study and major limitations in methodology, including data analysis, severely limit generalization of results. The study was presented at the 1981 Phyllis J. Verhonick Nursing Research Symposium, San Antonio, Texas.

APPENDIX D

STANDARDS OF NURSING PRACTICE

Independent Study Project
AMEDD OAC Class 101

Authors:
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CPT Paula Kanner, ANC

Edited By:
LTC Martha Bell, ANC

TABLE OF CONTENTS

TABLE OF CONTENTS (Continued):

TABLE OF CONTENTS (Continued):

TABLE OF CONTENTS (Continued):

TABLE OF CONTENTS (Continued):

STANDARDS OF NURSING PRACTICE

INTRODUCTION

The SONP were introduced in November 1979, revised and published in the DA PAM 40-5 entitled "Army Medical Department (AMEDD) Standards of Nursing Practice." Their purpose was to set minimal acceptable guidelines for the practice of nursing within the AMEDD.

In May 1983, the Chief, Army Nurse Corps created a special task force at West Point MEDDAC to determine the degree of implementation of the SONP throughout the HSC. The task force organized and analyzed data supplied by each MTF regarding methods used to implement the standards, and the degree and success of implementation. The results of this task force indicated several problem areas:

1) interpretation of each standard varied according to the facility;
2) no common implementation model existed between facilities; and
3) no evaluation tool existed that could be utilized in all facilities.

Three ANC officers in a recent AMEDD Officers' Advanced Course chose to use the findings as the basis for an independent study project designed to provide common interpretation and guidelines for implementation and evaluation of each standard, and delineate areas of responsibility for meeting the standards.

Information utilized in the development of this packet was largely obtained from MTF responses to the West Point Task Force. Particularly useful were packets provided by Departments of Nursing at Forts Belvoir, Knox, Dix and Madigan Army Medical Center. Special acknowledgments are made to MAJ Barbara K. Penn, from Nursing Education and Staff Development (NESD) Ft Dix, for her excellent continuing education program entitled: "Nursing Process Documentation," excerpts of which are contained herein.

It is hoped that this packet will prove useful to individuals in their attempts to further implement the SONP and in providing quality patient care.

DAVID E. DUELTGEN, CPT ANC
KAREN R. DRIGGERS, CPT(P) ANC
PAULA KANNER, CPT ANC

CHECKLIST FOR NEW OFFICER'S PERFORMANCE SKILLS

1. Maintains physical assessment skill proficiency.

2. Completes and records a nursing assessment on all assigned patients within the designated time limit.

3. Gives an efficient, comprehensive patient report to personnel on receiving shifts.

4. Successfully prioritizes nursing care problems when developing a care plan.

5. Correctly states nursing diagnosis, uses accepted terms delineating them from medical diagnoses.

6. Develops and properly documents nursing care goals; sets appropriate time frames for accomplishments.

7. Writes achievable nursing care goals which are mutually set by the patient and staff member.

8. Writes nursing orders to accomplish identified care goals.

9. Makes appropriate nursing care assignments; coordinates staff actions in the plan of care.

10. Consistently and completely documents discharge instructions.

11. Understands and adheres to the patient's Bill of Rights and nursing unit rules.

12. Orients each patient on admission to the patient role; documents appropriately.

13. Provides for patient privacy at all times.

14. Insures patients are informed of risks and benefits of special procedures and studies; insures witnessed consent forms are completed prior to the patient's being medicated or leaving for procedures.

15. Maintains patient confidentiality.

16. Maintains Cardiopulmonary Resusitation (CPR) certification.

FOR NEW OFFICER'S PERFORMANCE SKILLS (Continued):

17. Maintains familiarity with unit/MTF cardiac arrest procedures.

18. Maintains familiarity with emergency drugs, their actions and uses.

19. Is aware of the location and proper utilization of emergency cart and equipment.

20. Regularly attends unit/MTF inservices.

21. Meets annual ANC continuing education unit requirements.

22. Offers assistance and support to NESD programs.

23. Actively participates in peer review.

24. Serves as nursing representative on subcommittees as assigned.

25. Conducts quality assurance auditing as required.

26. Sets individual goals for professional growth addressing the standards of practice, e.g., completion of DA Form 67-8-1 Office Evaluation Report (OER) Support Form.

27. Identifies learning needs of peers as well as self; provides learning experience to meet those needs.

28. Seeks learning experiences that will improve leadership and managerial skills.

29. Provides inservices within own area of expertise and skill level.

STANDARD I: COLLECTION OF DATA

PRINCIPLE: The collection of data about the health status of the patient is systematic and continuous; prioritized by the immediate condition of the patient; communicated to appropriate persons; recorded and stored in a retrievable and accessible system.

INTERPRETATION: Nursing care is accomplished through the use of the nursing process. Assessment/data collection is the first step in nursing process documentation, and is the starting point in caring for the patient. A complete, thorough collection of data must be accomplished, and is essential to the identification of problems, development of goals, and planning of nursing actions. Nursing assessment is a continuous process, initially based on the immediate needs of the patient. Direction for the physical assessment is provided by the history. The clinician must recognize the differences between medical and nursing priorities and approaches to physical assessment. The focus of a medical assessment is on the patient's history, diagnosis, and necessary treatments. Nursing assessment is concerned with gathering all relevant information, identifying problems, evaluating how the patient is coping with his problems, and determining what assistance is needed. Multiple sources are utilized by the nurse to gather data. These include: interviews with the patient, family and significant others, health care providers, and other relevant persons; observation; verbal and non-verbal responses; physical exams; former medical records; diagnostic reports and consultations. Once the information is obtained, it must be clearly documented, prioritized, communicated, and made accessible to all members of the patient's health care team.

CLARIFICATION OF MYTHS:

1. While a complete, head-to-toe physical examination can be helpful and desirable, it is not always necessary, nor is it required by the Standards of Nursing Practice. The purpose of the physical assessment is to focus on the subsystem appropriate for planning the patient's care.

CLARIFICATION OF MYTHS (Continued):

For example, a young, healthy male admitted for knee surgery may only require a description of the neuromuscular system.

2. The completed nursing assessment is documented on DA Form 3888 (Medical Record - Nursing Assessment and Care Plan) and DA Form 3888-1 (Medical Record - Nursing Assessment and Care Plan, Continuation). These forms provide the baseline for continuous assessment and evaluation of the patient's condition and progress. Newly assessed data is documented either on the DA Form 3888, 3888-1, or the Standard Form (SF) 510,(Nursing Notes) as appropriate.

3. The initial nursing assessment and data base information become a permanent part of the patient's record. This record is not confined to the admitting patient unit, but is transferred with the patient to any receiving unit. The receiving nurse is not required to reinitiate these forms, but to reassess the patient and modify the care plan as necessary. These actions are then documented in the receiving nurse's note.

GUIDELINES FOR IMPLEMENTATION:

1. Provide a copy of DA Pam 40-5 to all professional nurses.

2. Provide instruction to nursing staff on appropriate interviewing techniques (see Annex A-1, A-2). Rationale: Skilled interviewing techniques allow the gathering of useful and meaningful nursing health data.

3. Provide educational material (classes, films, and/or self-study materials) on nursing physical assessment skills (see Annex B; Academy of Health Science (AHS) video tape (VT) #668 - Normal Physical Assessment; AHS VT #1693 - Assessing Patient Needs; AHS VT #11194 - Stop, Look and Listen). Rationale: Physical assessment skills are necessary, but not always provided in schools of nursing. Correct, effective techniques must be learned. Instructional methods should be geared toward the individual nurse's needs.

GUIDELINES FOR IMPLEMENTATION (Continued):

4. Clinical nurses are given instruction on documentation requirements and proper implementation of DA 3888 and DA 3888-1. (There are many diverse, currently approved overprints utilized throughout HSC. Each facility should determine their own needs for documentation and make use of these if they deem so necessary.) Rationale: Provides method for storage, documentation, and communication of data. References: AR 40-407, Nursing Records and Reports; AHS Programmed Instruction (PI) 61-29-344-1, Nursing Records and Reports.

5. Nursing assessments shall be reviewed, updated, and recorded as additional data is collected and patient needs change. Established review dates may be determined by local policy. Recommended review dates should coincide with DA and local MTF charting policies. Rationale: Ongoing assessment and review is necessary to determine the patient's progress and identification of new problems.

GUIDELINES FOR EVALUATION

	YES	NO
1. All professional nurses have copy of DA Pam 40-5.		
2. All nursing staff have received instruction on interviewing techniques. Documentation exists in unit inservice records.		
3. All professional nurses have been provided instruction on resource material in physical assessment skills.		
4. Clinical head nurses periodically review charts to insure proper use of documentation records. (Reference: Standard XII-Quality Assurance)		
5. Clinical head nurses review charts for timeliness of documentation and reassessment of patient needs.		

RESPONSIBILITIES

NURSING SCIENCE DIVISION, USA AHS
OFFICER BASIC COURSE

1. Provides DA Pam 40-5 to officers in each ANC Officer's Basic Course (OBC).

2. Utilizes AHS PI 61-29-3444-1, Nursing Records and Reports.

MTF NURSING EDUCATION AND STAFF DEVELOPMENT

1. Provides physical assessment classes or learning materials.

2. Provides DA Pam 40-5 to all professional personnel as necessary.

3. Offers classes on interviewing techniques.

MTF CLINICAL HEAD NURSE

1. Sets standards for peer review regarding documentation.

2. Provides reinforcement for physical assessment skills.

3. Provides reference material and reinforcement on interviewing techniques.

4. Provides orientation instruction on use of DA Forms 3888 and 3888-1.

5. Insures that nursing assessment is accomplished and recorded within appropriate time-frame.

6. Insures timely and comprehensive communication of data.

RESPONSIBILITIES (Continued):

INDIVIDUAL

1. Maintains physical assessment skills.

2. Maintains interviewing technique proficiency.

3. Completes and records nursing assessment on all assigned patients within designated time frame.

4. Gives an efficient, comprehensive report on patients to receiving shift.

ANNEXES FOR STANDARD I:

Annex A-1: "The Clinical Interview"

Annex A-2: "Interpersonal Interview Skills Guide"

Annex B: "Systems' Assessment and Documentation"

STANDARD II: NURSING CARE PROBLEMS

PRINCIPLE: Nursing care problems are derived from the health status data (stated as PROBLEMS on DA Form 3888-1, Medical Record - Nursing Assessment and Care Plan Continuation.)

INTERPRETATION: The second step in the nursing process is the planning of nursing care. Nursing care problems are identified by the Registered Nurse (RN) following a review of the history and assessment data. Nursing problems are expressed in clear, concise terms which are easily understood by, and communicated to others.

CLARIFICATION OF MYTHS:

1. Nursing care problems are not medical diagnoses or restatements of the medical diagnosis. The medical diagnosis identifies and labels a precise pathological disease. It is used to identify modes of prescribed treatment which either cure the disease or reduce the injury. The nursing care problem (Nursing Diagnosis) describes the effects of the symptoms and pathological conditions on the patient's activities and life style. It is a statement of the patient's behavioral response to the condition or situation.

2. In recent years, nursing diagnostic terms have been used in lieu of nursing care problems. Like a nursing care problem, the nursing diagnosis summarizes assessment data; however, it represents common terminology which describes specific objective phenomena. It also represents a clinical judgement by the RN and is a condition primarily resolved by nursing care methods. The nursing diagnosis can be used as a focus for projecting a desired outcome, e.g., measurable behavior indicating the problem is resolved, or progressing towards resolution.

3. Priority issues are problems of a life threatening nature, which are current and applicable to the patient's situation, or have potentially serious long term side effects.

GUIDELINES FOR IMPLEMENTATION:

1. Each RN will be provided with a list of currently accepted nursing diagnoses (nursing care problems). A copy will also be readily available on the nursing unit.

2. A ward specific performance based learning experience should be regularly provided on the nursing unit and during the orientation of newly assigned personnel. The practical part of the inservice should include, but not be limited to, emphasis that:

- the nursing care problem should describe potential as well as actual problems;

- each nursing care problem should be prioritized according to the patient's condition;

- the nursing care problem is written as a nursing diagnosis not a medical diagnosis;

- nursing care problems reflect identified patterns of behavior and/or coping mechanisms.

3. Through the use of peer review, an objective evaluation of the identified problems is recommended on a recurring basis. After reading the subjective and objective admission assessment data, the reviewer should be able to identify the same nursing problems as those identified by the admitting RN.

4. Specific problem list review and revision dates should be set by the head nurse based on the patient's classification and needs.

5. Nursing care problems, including the dates identified and resolved, will be listed on DA Form 3888-1.

6. Accountability for completion of DA Forms 3888 and 3888-1 should be included as a critical element in the performance standards of all unit RNs.

7. Unresolved nursing care problems will be addressed in the discharge plan. A plan for resolution will be discussed with the patient/significant other (SO).

GUIDELINES FOR EVALUATION

	YES	NO
1a. All RNs have a copy of currently accepted nursing care problems (nursing diagnosis).		
1b. A copy of currently accepted nursing care problems (nursing diagnoses) is readily available on all nursing units.		
2. There is documentation indicating all RNs have attended inservices reviewing the identification of nursing care problems and/or the use of nursing diagnoses.		
3. There is documentation of periodic chart reviews which validate identified care problems.		
4a. Policies regarding the review and revision of problem lists are available on nursing units.		
4b. Problem list review is documented on either the DA 3888-1 or the SF 510.		
5. The dates of problem identification, specific nursing care problems, and resolutions are documented on the DA 3888-1.		
6. Accountability for implementing the nursing process (specifically problem identification/care plan development) has been designated a critical element of performance standards of all RNs.		
7a. Discharge plans reflect unresolved nursing care problems.		
7b. There is documentation that a plan to address unresolved problems at discharge has been discussed with the patient/SO.		

RESPONSIBILITIES:

NURSING SCIENCE DIVISION, USA AHS
OFFICER BASIC COURSE

1. Provides an overview of all the Standards of Nursing Practice to students in the ANC OBC.

2. Provides a copy of DA Pam 40-5 to all officers in the ANC OBC.

3. Provides copies of currently accepted nursing diagnoses to all students in the ANC OBC.

4. Conducts practical exercises on identification of nursing care plan problems and/or nursing diagnoses.

MTF NURSING EDUCATION AND STAFF DEVELOPMENT

1. Coordinates Department of Nursing inservices on the SONP with classes for each standard.

2. Provides copies of currently accepted nursing diagnoses to RNs, as necessary.

3. Maintains documentation of attendance at nursing process inservices.

4. Assists in the process of applying for, or obtaining, continuing education units for the nursing staff.

5. Provides instruction on the nursing process to all newly assigned RNs, as necessary, during orientation.

6. Conducts periodic instructions on the nursing process (specifically problem identification/use of nursing diagnosis) as necessary.

MTF CLINICAL HEAD NURSE

1. Sets standards for peer review regarding the evaluation of the use of nursing diagnosis.

2. Provides ward specific inservices on nursing diagnoses. This should include examples of the components of nursing diagnoses and a practical exercise.

RESPONSIBILITIES (Continued):

MTF CLINICAL HEAD NURSE (Continued):

3. Sets review date standards based on the patient's conditions and needs.

ANNEXES FOR STANDARD II:

Annex C: "The Two Languages of Nursing and Medicine"

Annex D: " Nursing Diagnosis"

Annex E: "Nursing Diagnosis Do's and Don'ts"

Annex F: "Integrated Nursing Care Plan"

STANDARD III: NURSING CARE GOALS

PRINCIPLE: Nursing care goals, derived from the nursing problems and reflective of the prognosis, are formulated to provide a framework within which health care needs can be addressed and resolved.

INTERPRETATION:

1. The formulation of nursing care goals follows the planning phase of the nursing process. Goals are statements written as behavior outcomes describing behavior changes which will be brought about by nursing actions. They are based on the assessment and nursing diagnoses of the patient's health status and concerns. Nursing goals have four components: an action verb; the task to be performed; the specific standard or condition under which the task is to be performed; and the time frame for accomplishment of the task.

2. The purpose of goal setting is to give direction to the care and assist the patient to achieve his or her highest potential for wholeness/wellness. These goals are mutually agreed upon by the nurse and the patient or significant other. This allows the patient some independence and control, and encourages compliance with the care delivered. Goals reflect the restoration of health, the maintenance of a condition, the promotion of health, and/or preventive measures that can be taken to avoid illness.

CLARIFICATION OF MYTHS: Nursing care goals describe the intended outcome of nursing actions, not the process or what the nurse is going to do to meet the goals. A goal is written for each identified nursing care problem. On occasion, more than one nursing problem may be addressed by one nursing care goal. In such instances, identification of an additional goal is unnecessary.

GUIDELINES FOR IMPLEMENTATION:

1. Provide instruction to the nursing staff on the purposes and techniques of writing nursing goals. This instruction should include a practical exercise in writing nursing goals. Each participant should write goal statements from nursing diagnoses given in class

GUIDELINES FOR IMPLEMENTATION (Continued):

and evaluate that goal based on the components of goal statement. It is most beneficial if the nursing diagnoses were provided by the head nurse of each ward or unit. This will allow the participant the opportunity to practice utilizing realistic nursing problems from their own duty section.

2. The staff from each unit should prepare a list of acceptable nursing goal statements based on the type of nursing care problems routinely identified on that unit. A copy of these goal statements should be easily accessible to all staff members.

3. Unit peer review should provide documentation regarding assessment criteria established for writing nursing care goals. At a minimum, the criteria for evaluation should: a) begin with an action verb; b) state the specific task to be performed; c) set a time frame for accomplishment; d) determine if goals were mutually set; e) evaluate the goals for realistic achievement; and f) assess if the goals reflect a logical outcome for the nursing diagnoses.

4. Conduct multi-disciplinary team conferences to promote the communication of nursing goals about specific patients to other health care professionals.

5. Incorporate the nursing goals and actions in change of shift reports. This will provide a forum for review and revision.

GUIDELINES FOR EVALUATION:

	YES	NO
1. There is documentation that all nursing staff have received instructional classes and completed a practical exercise in writing nursing care goals.		
2. Each nursing unit has prepared a list of acceptable nursing care goals based on the type of nursing care problems routinely identified on that unit. These nursing care goals are utilized in the patient's chart.		

GUIDELINES FOR EVALUATION (Continued):

	YES	NO
3. There is peer review documentation at the unit level indicating the nursing goals meet the minimum standards as stated in "Guidelines for Implementation, #3".		
4. Nursing care goals are identified in writing on the DA Form 3888-1 and are communicated in the change of shift reports.		

RESPONSIBILITIES:

NURSING SCIENCE DIVISION, USA AHS
OFFICER BASIC COURSE

1. Conducts an overview of all the Standards of Nursing Practice to all students attending the ANC OBC.

2. Provides a copy copy of DA Pam 40-5 to each officer attending the ANC OBC.

3. Provides a practical exercise class on nursing process documentation to students attending the ANC OBC.

MTF NURSING EDUCATION AND STAFF DEVELOPMENT

1. Coordinates appropriate hospital-wide inservice on the Standards of Nursing Practice with specific classes on each standard.

2. Provides individual instruction and evaluation of written goal statements during orientation of newly assigned personnel.

MTF CLINICAL HEAD NURSE

1. Sets peer review evaluation criteria for goal assessment.

2. Provides ward specific inservices on nursing care goals appropriate for patients routinely admitted to the unit.

RESPONSIBILITIES (Continued):

MTF CLINICAL HEAD NURSE (Continued):

3. Develops a list of nursing care goals for types of patients routinely admitted to the nursing unit.

4. Insures nursing goals and actions are incorporated in the change of shift report.

ANNEXES FOR STANDARD III:

Annex G: "Patient Goals"

Annex H: "Individual Responsibilities for Documentation in the Clinical Record"

STANDARD IV: NURSING CARE PLAN

PRINCIPLE: The nursing care plan, based on patient needs, is the systematic method developed to achieve stated patient goals.

INTERPRETATION:

1. The care plan includes the nursing assessment with problem and goal identification; a logical sequence of nursing actions/orders to attain the goals; management of individual risk factors; utilization of appropriate resources; patient and family education. Through the use of the nursing process, care plans are individualized for all patients.

2. Identified goals should be accompanied by nursing actions/orders. In turn, nursing orders are supported by documented data, diagnoses and goals.

3. It is essential to involve the patient and significant others in care plan development. Through the use of careful interviews, appropriate data about a prehospitalization status and knowledge base can be gathered to tailor the plan of care to the individual patient.

CLARIFICATION OF MYTHS:

1. Standardized care plans may supply a basic beginning for the plan of care, but should be modified and individualized as necessary. Individuals have varied needs despite common disease processes.

2. The plan of care does not simply begin on admission and end at discharge. When applicable, prehospitalization preparation for admission should be accomplished. At time of discharge, follow-up plans must be communicated to patient and documented in chart.

GUIDELINES FOR IMPLEMENTATION:

1. Each RN must master care plan development. Instruction on the nursing process should be done for those nurses who lack necessary skills.

GUIDELINES FOR IMPEMENTATION (Continued):

2. Nursing care problems and corresponding nursing orders are to be numbered to assist in tracking the progression from needs through actions. (Annex F)

3. Regularly scheduled patient care conferences will facilitate "brainstorming" and the use of more than one individual's expertise.

4. Printed information, including routine ward activities, relevant hospital policies, and available services, e.g., chaplain and social service, should be made available to all patients and their families on admission to the nursing unit.

5. Patient education is extremely important and must be documented in patient records. Inservices can be utilized to aid staff in developing patient education plans.

6. Nursing care plans should be utilized during change of shift reports, thus facilitating timely review and revision prior to patient care assignments.

GUIDELINES FOR EVALUATION:

	YES	NO
1. Nursing care plans are initiated on all patients within 48 hours of admission.		
2. Identified nursing care problems correlate with nursing orders.		
3. The care plan is written and signed by an RN.		
4. Orientation of the patient is documented on admission.		
5. Documented discharge planning includes follow up care, patient instruction, and the patient's understanding of the plan.		
6. If a standardized care plan is used, individual goals are also identified.		

GUIDELINES FOR EVALUATION (Continued):

	YES	NO
7. Care plans are reviewed and updated in a timely manner based on the condition of patient.		

RESPONSIBILITIES:

MTF NURSING EDUCATION AND STAFF DEVELOPMENT

1. Provides educational program on nursing process as it relates to care plan development, emphasizing medical-legal considerations for the documentation of care.

MTF CLINICAL HEAD NURSE

1. Establishes unit criteria for discharge planning.

2. Provides time for and directs patient care conferences.

3. Insures utilization of care plans during change of shift report.

4. Insures review and revision of care plans in a timely manner.

5. Evaluates staff's ability to successfully utilize the nursing process.

INDIVIDUAL

1. Masters use of nursing process in development of care plan.

2. Initiates care plan within 48 hours of patient admission.

3. Assures that patient care goals are mutually decided on by patient and staff.

4. Develops communications skills in order to participate in nursing reports, care conferences, and patient education.

ANNEX FOR STANDARD IV:

Annex F: "Integrated Nursing Care Plan"

STANDARD V: NURSING ACTION

PRINCIPLE: Nursing actions/orders are prescribed with participation of patient, family, and/or significant others to implement the plan of care.

INTERPRETATION:

1. Nursing orders correspond with the implementation phase of the nursing process. They are written guidance for what the nursing staff must do to help the patient meet the established goals.

2. Prescribed nursing actions should address the following patient needs: safety, management of risk factors, measures to accomplish goals, adaptation to changes in body function, incorporation of family in plan of care, patient education.

3. Nursing orders written by an RN, are developed for accomplishment of specific identified goals. The orders identify an action to be performed, how, where, and by whom it is to performed. Each nursing order should have an action verb. Documentation of order completion is essential and will be noted with the date and initial of the responsible care provider on the DA Forms 4677 (Therapeutic Documentation Care Plan - Non-medication) and 4678 (nerapeutic Documentation Care Plan - Medication).

GUIDELINES FOR IMPLEMENTATION:

1. Nursing orders will be numbered to correspond with the problem/goal statement to facilitate quality assurance monitoring. (Annex F)

2. Weekly unit level chart audits on randomly chosen charts should be completed to identify discrepancies in meeting the standard.

3. The ability to write nursing orders should be incorporated in RN performance standards.

4. Education programs on documentation of nursing orders be utilized at MTFs.

GUIDELINES FOR IMPLEMENTATION (Continued):

5. Departmental standing operating procedures (SOP) should be established to define actions falling within the purview of nursing to prescribe.

GUIDELINES FOR EVALUATION:

	YES	NO
1. Individual nursing orders are documented for each care goal.		
2. Nursing orders are numbered to reflect corresponding patient care goals/problems.		
3. Nursing orders are supported by assessment data, diagnoses, and goals.		
4. Nursing orders are revised and/or discontinued as appropriate.		
5. Nursing orders are timed, dated, and initialed by ordering nurse.		
6. Specific audit criteria are established for nursing orders.		

RESPONSIBILITIES:

MTF NURSING EDUCATION AND STAFF DEVELOPMENT

1. Provides programmed instruction regarding the use and development of nursing orders.

MTF CLINICAL HEAD NURSE

1. Develops monitoring mechanisms to identify unit problem areas and strengths.

2. Facilitates involvement of patient and/or significant other in plan of care.

RESPONSIBILITIES (Continued):

INDIVIDUAL

1. Develops ability to write nursing orders.

2. Documents nursing actions on the DA Forms 4677 & 4678.

3. Involves patient and significant other in plan of care.

ANNEX FOR STANDARD V:

Annex F: "Integrated Nursing Care Plan"

STANDARD VI: IMPLEMENTED CARE PLAN

PRINICIPLE: Documentation is integral to the implementation of the plan of care.

INTERPRETATION:

1. The implementation of the care plan should be documented and focused on the patient's safety, psychological, physiological, and educational needs. Implementation is accomplished by nursing personnel, the patient himself, and/or significant others who are sufficiently skilled to provide for nursing care needs. Following coordination with the charge nurse responsible for making patient care assignments, the RN responsible for the individual patient initiates the care plan. Implementation is modified based on patient condition. Modification can be accomplished during change of shift reports and nursing rounds.

2. Documentation of the implementation must include patient status, response to nursing actions, capabilities and limitations in reaching expected outcomes, and additional identified problems. The degree of goal achievement or nonachievement must be documented in a timely fashion and should be addressed prior to the time desingated for goal accomplishment. Documentation also includes a summary of pertinent discharge instructions and the patient's/significant other's understanding of such instructions.

CLARIFICATION OF MYTHS: While the clinical head nurse or charge nurse is ultimately responsible to insure completion and documentation of nursing interventions, all individual care providers are also responsible for completion and appropriate documentation of their portions of the care.

GUIDELINES FOR IMPLEMENTATION:

1. Orienting RNs should receive guidance in making appropriate nursing care assignments and how to tailor an individual's skill level to the nursing care needs of the patient. New nursing personnel should be assisted in learning how to reassess and reassign based

GUIDELINES FOR IMPLEMENTATION (continued):

on patient status. This assistance could best be accomplished through a preceptorship program for new graduates.

2. Documentation of implementation must be done to provide proof that actions were completed. Consistent standardized methods are recommended in order to prevent omission of legally important documentation. Completion of nursing care is documented with initials on the DA Forms 4677 or 4678.

3. Omission of prescribed orders is documented with a circle in the appropriate block of the DA Form 4677 and 4678. A corresponding notation of the reason for omission should be written in the SF 510 during the shift in which the omission occurred.

4. The degree of goal achievement should be addressed in the nursing notes. This should be addressed prior to the date of expected achievement and prior to the day of discharge.

5. Documentation of discharge planning should include: instructions, e.g, medications, limitation of activities, diet, follow-up care, and patient's level of understanding of instructions.

6. Regularly scheduled quality assurance monitoring will be done to identify problems and strengths of documentation.

GUIDELINES FOR EVALUATION:

	YES	NO
1. Content of preceptorship or orientation programs include instructions on making appropriate patient care assignments.		
2. There are established procedures for the assignment of patient care.		
3. All current medical and nursing orders are initialed on DA Forms 4677 & 4678.		

GUIDELINES FOR EVALUATION (Continued):

	YES	NO
4. Reason for omission of an order is documented in the nursing notes.		
5. Patient progress toward goal achievement is documented in nursing notes.		
6. Discharge planning was appropriate for the patient's condition and length stay.		
7. Documentation of discharge instruction and counseling is included in the nursing notes.		
8. Documentation of discharge instruction includes an indication of the patient's level of understanding.		
9. Patient care assignments are documented on assignment sheet.		

RESPONSIBILITIES:

NURSING SCIENCE DIVISION, USA AHS
OFFICER BASIC COURSE

1. Directs graduates to be prepared to identify learning objectives regarding team leadership prior to arrival at first duty assignment.

MTF NURSING EDUCATION AND STAFF DEVELOPMENT

1. Provides instruction on discharge planning and documentation to personnel.

2. Assists individual nursing units to develop unit specific patient education programs, e.g., preoperative teaching.

RESPONSIBILITIES (Continued):

MTF CLINICAL HEAD NURSE

1. Oversees implementation of care plan and redirects nursing staff when changes in patient status occur.

2. Insures that RNs given charge positions can effectively make assignments and monitor the care delivery.

3. Insures that new graduates are provided with necessary supervision during their initial leadership experiences.

4. Is ultimately responsible for insuring that personnel assigned to implement the plan of care are sufficiently skilled to do so.

INDIVIDUAL

1. Successfully coordinates care through appropriate patient assignments.

2. Gives concise, pertinent nursing reports and modifies care plan implementation based on patient care status.

3. Consistently documents degree of goal achievement in a timely manner.

4. Consistently and completely documents discharge instruction.

STANDARD VII: REASSESSMENT OF PATIENT PROGRESS

PRINCIPLE: The patient's progress or lack of progress toward goal achievement (as assessed by the patient, family and/or significant other, and nurse) directs: the reassessment and reordering of priorities; new goal setting; and revision of the plan of care.

INTERPRETATION: This standard correlates with the evaluation phase of the nursing process. Using the nursing assessment, goals, and nursing orders, the nurse objectively reassesses the patient's progress. The process is incomplete without this step. It is unknown if nursing actions have achieved stated objectives. Evaluation and reassessment of nursing care is of mutual concern to all members of the health care team. The patient and family must also be involved in this reassessment. As the object of the nursing action they play an important role in determining the effectiveness of the care. Once achieved, the objective may be deleted from the plan of care. The care plan must be revised to address unmet patient needs.

GUIDELINES FOR IMPLEMENTATION:

1. Nursing goals should be incorporated in the report at the change of shift, thus allowing the entire nursing staff to discuss patient progress. Alternative approaches as well as care plan revisions can be disseminated to the staff. This also allows each nurse to evaluate the patient's progress. DA Form 3888-1 should be used when giving report.

2. A daily nursing note should address the patient's progress toward goal achievement. It is recommended that problem oriented nursing records be implemented where appropriate.

3. It is recommended that as the nurse makes rounds during the change of shift, goals and progress are reviewed and communicated with the patient and documented in the patient record.

GUIDELINES FOR IMPLEMENTATION (Continued):

4. The discharge note should identify the degree of accomplishment of the mutually set goals. The patient should be given written instructions to assist in home care.

5. Each unit should develop specific outcome criteria for the types of patients routinely admitted to the unit, thus setting a standard for evaluating the overall plan of care, goals set, and care delivered to the patient (Quality Assurance Standard XII).

GUIDELINES FOR EVALUATION:

	YES	NO
1. The DA Form 3888-1 (Nursing Care Plan) is used during change of shift report.		
2. Patient progress towards goal achievement is discussed during change of shift report.		
3. The patient's progress toward goal achievement is documented in the nursing note.		
4. There is documentation that goals have been communicated with the patient and/or significant other.		
5. The discharge plan or note addresses patient progress toward goal achievement.		
6. Outcome criteria specific for the types of patients admitted to a nursing unit have been established.		
7. Medical record audits reflect utilization of the outcome criteria.		

RESPONSIBILITIES:

NURSING SCIENCE DIVISION, USA AHS
OFFICER BASIC COURSE

(see Standard III)

RESPONSIBILITIES (continued):

MTF NURSING EDUCATION AND STAFF DEVELOPMENT

(see Standard III)

MTF CLINICAL HEAD NURSE

(see Standard III)

STANDARD VIII: PATIENT'S INDIVIDUAL RIGHTS

PRINCIPLE: Nursing practice supports and preserves the basic rights of patients for independence of expression, decision and action, and is concerned for personal dignity and human relationships.

INTERPRETATION: Nursing practice recognizes that human beings have certain intrinsic rights which extend to the health arena. The patient and family in our care retain the basic consumer rights to safety, to be informed, to choose, and to be heard. Often, in the past, hospitalization has meant that the patient lost control over certain aspects of his life, and was provided care that was impersonal and fragmented. Part of nursing's responsibilities include serving as patient advisor. The role entails being sensitive to consumer rights and protection, and providing a system of health care where the consumer's needs are given priority.

CLARIFICATION OF MYTHS:

1. A patient's rights are not served by posting a copy of the ward rules near his bed. While this informs him of his responsibilities as a patient in that unit, it does not inform him of his individual rights.

2. Patient advocacy and protection are not the sole responsibility of the Hospital Patient Representative, but of all health care providers.

3. Preventing litigation is an important, but not the ultimate goal of the patient representative. Respecting the patient's rights and providing safe, effective care are the priorities. Meeting these requisities will assist the hospital in avoiding litigation.

GUIDELINES FOR IMPLEMENTATION:

1. Publication of a "Patient's Bill of Rights" which includes reference to respectful care, the right to: information regarding diagnoses, treatment and prognosis; informed consent; refusal of treatment; privacy

GUIDELINES FOR IMPLEMENTATION (Continued):

and confidentiality; refusal to participate in experiments; continuity of care; billing procedures, hospital rules and regulations. Publishing such a document affirms the institution's dedication to individual rights.

2. Each nursing unit publishes a set of ward rules and patient responsibilities to delineate aspects of ward policies which affect patient care and behavior.

3. At admission, each patient recieves a copy of the "Patient's Bill of Rights" and ward rules. Further explanation is provided by nursing personnel as appropriate to provide the patient access to information pertinent to hospitalization.

4. A designated patient representative is available to patients and their families. The position and respsonsibilities of the representative are widely publicized. The patient representative serves to defend and protect the patient in the hospital setting. The representative also serves as a channel through which problems, concerns and unmet needs can be addressed.

5. Orientation to the patient role and nursing unit is provided by nursing personnel. The orientation familiarizes the patient with surroundings and upcoming events. Such knowledge may increase safety and reduce stress. Specifically, orientation should review ward rules and responsibilities, safety issues, equipment and facilities use, safeguarding of valuables, explanation of procedures, appointments and visitation. The orientation is documented in the nursing notes.

6. A comprehensive nursing care plan is developed based on the patient assessment and identified needs; the care plan is regularly reviewed, revised, and shared with other health care providers.

7. Each patient, and family as appropriate, are fully counseled, with written consent obtained prior to all special procedures and studies.

8. Personal privacy is provided with screens or curtains between patients for examinations, treatment, or personal interviews.

GUIDELINES FOR IMPLEMENTATION (Continued):

9. Privacy and confidentiality of the medical record is maintained by locating records in a secure environment and limiting access to only those involved in the care.

10. Personalized teaching is part of a comprehensive care of the patient. Nursing staff provide patient and family with education pertinent to diagnosis, treatment and care, and appropriate to their level of understanding.

11. All nursing personnel are trained and certified in CPR and other skills and equipment appropriate to their working environment.

12. All ward equipment is inspected regularly and maintained in accordance with specific requirements.

GUIDELINES FOR EVALUATION:

	YES	NO
1. A "Patient's Bill of Rights" is published and provided to all patients on admission.		
2. Ward rules are published and provided to all patients on admission.		
3. A patient representative is designated, available and publicized.		
4. All patients' charts have documentation of orientation to ward, safeguarding of valuables and explanation of procedures.		
5. Each patient has a comprehensive, current care plan which is available to all health care providers.		
6. Signed and witnessed operative permits are in patients' charts prior to all special procedures or studies.		
7. All patient areas have means to provide physical privacy.		

GUIDELINES FOR EVALUATION (Continued):

	YES	NO
8. Medical records are maintained in a secure environment with limited access.		
9. Documentation of patient and family education exists in the health care record.		
10. All ward equipment is labeled with inspections and maintenance information.		

RESPONSIBILITIES:

MTF NURSING EDUCATION AND STAFF DEVELOPMENT

1. Emphasizes patient rights during initial hospital orientation.

2. Provides classes/information on patients' rights and comprehensive care as necessary.

3. Provides resources to nursing staff for patient education.

MTF CLINICAL HEAD NURSE

1. Insures all staff are knowledgeable on the Patients' Bill of Rights and rules.

2. Periodically reviews patient charts for documentation of orientation to patient role.

3. Provides instruction on the role of the patient representative.

4. Insures all staff are certified and credentialled as necessary.

5. Insures ward equipment is maintained and inspected regularly.

6. Insures medical records are secure from unauthorized access.

RESPONSIBILITIES (Continued):

MTF CLINICAL HEAD NURSE (Continued):

7. Insures nursing process carried out to provide comprehensive, planned care meeting each patient's identified needs.

8. Emphasizes the need for a signed consent form on patient's chart prior to special procedures.

9. Insures adequate/rooms/screens are available to provide for patient privacy.

INDIVIDUAL

1. Understands and adheres to the Patient's Bill of Rights and ward rules.

2. Provides and explains the Patient's Bill of Rights and ward rules to each patient on admission.

3. Is knowledgeable about the patient representative and contacts same as needed.

4. Orients each patient on admission to the patient's role and documents appropriately.

5. Assesses and plans individualized care for each patient.

6. Insures patients are informed of risks and benefits of special procedures and studies, and sign a witnessed consent form prior to being medicated or leaving for procedures.

7. Provides for patient privacy at all times.

8. Maintains confidentiality of patients.

9. Assesses patient and family needs and provides teaching appropriate to the condition and level of understanding. Documents said teaching in patient record.

10. Maintains personal certification and competency as needed.

STANDARD IX: CLINICAL NURSING RESEARCH

PRINCIPLE: Clinical nursing research is ethical, responsible, and relevant to nursing practice. The concept of research includes not only the acquisition of knowledge, but also the recognition that knowledge is to be used for improvements in health care.

INTERPRETATION:

1. As nursing continues to strive for professional recognition research becomes an imperative component. Part of professional responsibility involves extending the base of knowledge, and using scientific means to document the validity of a practice. Coexistent with the need to discover knowledge through research is the necessity to implement this new knowledge for the benefit of the patient. This implies a responsibility for each individual nurse to keep abreast of current theory and research, and utilize findings as appropriate for the patient population served.

2. Each nurse has an obligation to examine professional practices and determine which are in need of scientific justification. Registered nurses should initiate research based on professional introspection. The participation in multidiscipline focused research is equally important. Regardless of the role (e.g, consultant, subject, consumer, clinician providing supportive care to a research subject, technical assistant, co-investigator), the RN remains a patient advocate, insuring adherence to legal and ethical considerations.

CLARIFICATION OF MYTHS: Research need not be a "doctoral-like" production. Informal research is conducted whenever two methods of treatment are compared to determine which is the better. However, more sophisticated accomplishment of these actions, via the research process, lends credence to nursing's body of knowledge and practice modalities.

GUIDELINES FOR IMPLEMENTATION:

1. ANC officers should be provided encouragement and assistance to work towards and obtain advanced nursing degrees. Rationale: Graduate and postgraduate education have a strong focus on the research process and nursing theories.

2. In the absence of a Nursing Research Service, local Departments of Nursing (DON) should develop research committees to facilitate nursing research within their MTFs. Committee members may include individuals with research background and others interested in the advancement of nursing through research. Rationale: Such a group should be familiar with methodologies and ethical responsibilities, and serve as a resource for the facility's RNs interested in conducting or participating in research.

3. Senior DON management personnel, e.g., Chief Nurse (CN), Assistant Chief Nurse (ACN), supervisors, and clinical head nurses should encourage nursing research by identifying areas of need (e.g., through quality assurance) and interest, and by providing assistance to the researcher. Rationale: Interest in and importance placed on an issue are often transmitted vertically and horizontally.

4. Nurses should be encouraged to participate in research conducted by colleagues in other health care disciplines. Rationale: Active participation allows the nurse to serve as patient advocate and to become familiar with the research process.

5. Nursing unit/section journal clubs can be used to discuss and evaluate new findings and determine the applicability to practice at the local MTF. Rationale: This provides a forum to find and discuss articles and research results with peers.

6. Nursing research articles and journals should be maintained on the unit and in hospital libraries. Rationale: This provides greater accessibility to current literature and advances in the field.

7. Nurses should be encouraged to participate in and attend the Phyllis Verhonick Nursing Research Symposium.

GUIDELINES FOR EVALUATION:

	YES	NO
1. Interest and enthusiasm for nursing research generated by the Chief Nurse's Office (CNO).		
2. Nursing research service or committee present and active.		
3. As possible, nurses pursuing advanced degrees are given assistance with work schedules.		
4. Areas of possible research are identified at quality assurance, head nurse, section supervisor meetings.		
5. RNs are involved in multidisciplined research.		
6. Patients participating in research studies are informed of their rights, have consented, and are treated in an ethical manner.		
7. Journal clubs are active on ward.		
8. References (e.g., periodicals) are available on nursing units and in the hospital library.		
9. A nursing representative attends the PJ Verhonick symposium and reports to MTF.		

RESPONSIBILITIES:

NURSING SCIENCE DIVISION, USA AHS
OFFICER BASIC COURSE

1. Stresses the role of the ANC officer as a professional with responsibility to conduct and participate in research.

RESPONSIBILITIES (Continued):

MTF NURSING EDUCATION AND STAFF DEVELOPMENT

1. Serves as resource for formation of journal clubs on units/sections.

2. Distributes news of current research in NESD bulletin.

MTF CLINICAL HEAD NURSE

1. Encourages and promotes research in clinical area.

2. Identifies areas of research need and interest within unit.

3. Encourages participation in multidisciplined/collaborative research.

4. Develops nursing unit level journal club with focus on nursing research findings.

5. Maintains nursing research articles and journal library on ward.

INDIVIDUAL

1. Begins and continues work on advanced degree.

2. Identifies areas of interest in nursing research.

3. Participates in research.

4. Participates in nursing unit journal club.

5. Reads current literature on nursing trends and research.

STANDARD X: CARDIOPULMONARY RESUSCITATION (CPR) COMPETENCY

PRINCIPLE: Nursing practice provides for competency in administering cardiopulmonary resuscitation and employing definitive drug therapy.

INTERPRETATION: Competency in CPR is based on a thorough working knowledge of basic life support. Familiarization with unit and hospital SOPs regarding cardiac arrest protocol, location and operation of all emergency equipment, and commonly used emergency drugs is also essential. Knowledge regarding CPR drugs must include drug action, usual dosage and location on CPR cart. Cardiopulmonary certification must be provided to all nursing personnel involved in direct patient care. Recertification must be provided on an annual basis.

CLARIFICATION OF MYTHS: Annual recertification is an excellent first step in the implementation of this standard but does NOT satisfy all requirements.

GUIDELINES FOR IMPLEMENTATION:

1. Crash carts should be standardized within each installation to facilitate efficient use by all hospital personnel.

2. Emergency equipment should be checked by the RN at least daily to insure equipment is available and operational. When possible, equipment should be checked each shift. Rationale: JCAH requires daily equipment checks. Such procedures afford the opportunity for frequent familiarization with location and proper operation of all equipment. The RN is responsible for administration of drugs and should be familiar with all crash cart contents.

3. The cardiac arrest SOP must be be reviewed by nursing personnel during hospital and unit orientation. Documentation of the review should be maintained within the MTF as designated in the local Department of Nursing Administrative Policy (DNAP).

GUIDELINES FOR IMPLEMENTATION (Continued):

4. CPR certification is provided to all nursing personnel with annual recertification under the auspices of national organizations, such as the American Red Cross and American Heart Association. A central authority (e.g, NESD) will monitor the activity. Rationale: Centralized monitoring provides readily available documentation for audit and inspection. Identification of needs for recertification classes is facilitated.

5. Knowledge of commonly used drugs, their doses and location on the crash cart must be demonstrated annually. This should be done in conjunction with CPR recertification for professional personnel. Rationale: The RN has responsibilty for knowing actions and doses of all drugs administered. When this instruction coincides with CPR recertification, documentation of compliance with the standard is readily available.

6. Ongoing evaluation of personnel competency can be accomplished through the use of "mock codes." Rationale: "Mock codes" provide a safe, nonthreatening means to familiarize individuals with their role and responsibilities during a cardiac arrest.

GUIDELINES FOR EVALUATION:

	YES	NO
1. Emergency carts setups are standardized throughout the hospital.		
2. Checklist maintained on emergency cart with verification of daily inspection by RN.		
3. There is a current hospital SOP addressing cardiac arrest protocol with documentation of review by nursing personnel.		
4. There is documentation, in a centralized location, of annual CPR certification of all nursing personnel.		

GUIDELINES FOR EVALUATION (Continued):

	YES	NO
5. Credentialling documents verify that all RNs have passed a written exam on common emergency drugs. (See Annex I)		
6. There is documentation indicating that "mock codes" are conducted quarterly in each unit.		

RESPONSIBILITIES:

MTF NURSING EDUCATION AND STAFF DEVELOPMENT

1. Maintains overall hospital documentation of achievement of the standard.

2. Coordinates hospital CPR classes for certification.

3. Coordinates drug classes with CPR classes.

4. Conducts other hospital inservices related to Standard X.

MTF CLINICAL HEAD NURSE

1. Coordinates ward inservices on crash carts, "mock codes," location and use of emergency equipment.

2. Verifies review and compliance with cardiac arrest SOP.

3. Insures that all personnel are proficient in knowledge of individual roles and responsibilities during cardiac arrest.

INDIVIDUAL

1. Has read and is familiar with SOP on cardiac arrest.

2. Maintains current CPR certification.

3. Is familiar with emergency drugs, actions and uses.

RESPONSIBILITIES (Continued):

INDIVIDUAL (Continued):

4. Is familiar with crash cart.

5. Knows location and proper utilization of emergency equipment.

6. Actively participates in "mock codes."

ANNEXES FOR STANDARD X:

Annex I-1: "Course Outline: Emergency Drugs Review"

Annex I-2: "Emergency Drugs Review: Pretest - Post test"

STANDARD XI: CONTINUING EDUCATION

PRINCIPLE: Nursing practice-based knowledge is expanded and improved by continuously and critically utilizing nursing theories and research findings.

INTERPRETATION: Each individual nurse has the responsibility to keep his knowledge base current and to make changes in practice based on changes substantiated by research findings. This requires active involvement in generating knowledge (see Standard IX) and a personal commitment to finding and utilizing information.

CLARIFICATION OF MYTHS:

1. Mandatory continuing education verification is not a punishment to be endured; rather it should be viewed as an attempt to require nurses to keep abreast of changes in nursing and medicine, and legitimize the question of current clinical competence.

2. Attending ward inservice offerings is an excellent step in the CE process. Compliance with the standard, however, requires a more active role in pursuing knowledge of current trends and findings in the profession.

GUIDELINES FOR IMPLEMENTATION:

1. Unit inservices should be conducted in accordance with (IAW) local policy. Bi-weekly presentations are recommended, available to all personnel.

2. Attendance at conferences is highly encouraged; funding is made available for attendance to nursing personnel.

3. Routine conferences, seminars, and programs, should be sponsored by the MTF Nursing Education and Staff Development service (IAW local policy) offering the amount of continuing education units (CEUs) necessary to meet ANC standards.

4. Inservice/program topics vary and are based on identified needs in the MTF.

GUIDELINES FOR IMPLEMENTATION (Continued):

5. Individual nursing practice reflects adherence to Standards of Nursing Practice.

6. RNs participate on hospital nursing committees and in peer review.

GUIDELINES FOR EVALUATION:

	YES	NO
1. Record of each individual's current licensure, CPR certification, CEUs, attendance at inservices and/or civilian education is maintained at the unit and central location.		
2. Performance appraisals/OERs reflect efforts at continuing education.		
3. Nursing unit inservice program and attendance records are maintained on the individual unit and with the NESD.		
4. There is a "Ward Education Facilitator" (WEF) identified for each nursing unit to coordinate inservices and distribute information on opportunities.		
5. Records of temporary duty (TDY) funding for continuing education are maintained within NESD and/or the CNO.		
6. Written reports of attended courses are submitted to NESD/CNO by individuals receiving government funding. These individuals are utilized for ward/hospital presentations as necessary and appropriate.		
7. Records of NESD routine and special educational offerings are maintained by the NESD/CNO.		
8. Interest/need surveys are routinely conducted by NESD for program/inservice planning.		

GUIDELINES FOR EVALUATION (Continued):

	YES	NO
9. There is unit level documentation of individual adherence to the SONP.		
10. Each RN serves periodically on nursing committees IAW local policy.		
11. Each RN participates in peer review.		
12. Individuals maintain subscriptions to nursing journals.		

RESPONSIBILITIES:

NURSING SCIENCE DIVISION, USA AHS
OFFICER BASIC COURSE

1. Informs new officers of ANC requirements and opportunities available to meet CE requirements.

2. Offers CEUs for OBC courses as appropriate.

3. Distributes DA Pam 40-5, as guide for individual practice.

MTF NURSING EDUCATION AND STAFF DEVELOPMENT

1. Maintains documentation of unit level inservices.

2. Conducts routine seminars and programs IAW local policy, offering at least the number of CEUs necessary to meet ANC standards.

3. Conducts need/interest surveys to establish topics for inservices.

4. Maintains individual records of state of licensure, CPR certification, CEUs, attendance at inservices, and educational advances.

5. Works with the WEF as necessary.

RESPONSIBILITIES (Continued):

MTF NURSING EDUCATION AND STAFF DEVELOPMENT (Continued):

6. Displays and distributes information on conferences/seminars available locally and area-wide.

7. Maintains record of persons receiving TDY funds; insures summary and evaluation of program is submitted in a timely fashion.

MTF CLINICAL HEAD NURSE

1. Informs staff of minimum CEU requirements and encourages activities to obtain them.

2. Appoints WEF and coordinates unit inservices to insure bi-weekly offerings.

3. Distributes information on conferences/seminars among ward personnel, and authorizes ward absence when possible.

4. Provides time for staff to attend NESD programs.

5. Surveys staff to identify inservice needs.

6. Encourages formation of journal club for professional staff.

7. Reflects achievement of continuing education objectives on performance appraisals.

8. Models own practice on the SONP.

9. Encourages volunteers and makes appointments to nursing committees.

10. Insures an active nursing unit peer review process.

INDIVIDUAL

1. Aware of Army and state of licensure CEU requirements.

2. Identifies own learning needs.

RESPONSIBILITIES (Continued):

INDIVIDUAL (Continued):

3. Attends bi-monthly unit inservices.

4. Supports NESD programs.

5. Practice reflects adherence to the SONP.

6. Actively participates in hospital nursing committees.

7. Actively participates in unit peer review.

8. Practice reflects knowledge of trends and research in patient care.

STANDARD XII: QUALITY ASSURANCE

PRINCIPLE: Nursing practice is reviewed and evaluated in a systematic manner to assure excellence in patient care.

INTERPRETATION:

1. Hospitals and nursing are similar to other organizations that must somehow measure the quality of their products. In nursing's case, the product is patient care. Data that measures the quality of care is derived from several sources: a) the organization, or structure within which nursing care is provided; b) the process, or actual nursing care that is provided; and c) the patient outcome, or response to the organization and process.

2. The purposes behind a quality assurance program need to be clearly defined. They include:

- obtaining feedback from patients;
- correcting care deficits;
- motivating nursing staff;
- conducting nursing research on nursing methods;
- decreasing possibility of litigation.

3. The process of quality assurance is composed of three steps: a) setting criteria/standards; b) surveillance of standards; and c) taking corrective action based on feedback.

4. Criteria for measurement may be found in several sources. Most Army MTFs operate under standards set by the JCAH; regular evaluations are conducted to determine compliance with standards. Criteria are more specific at nursing departmental and unit levels. These criteria include: the SONP; patient outcome standards (set on admissions); performance standards (derived from duty descriptions); nursing philosophy and objectives (from the DNAP), nursing care standards; and hospital policies and procedures.

CLARIFICATION OF MYTHS:

1. Quality assurance and control should be viewed as a challenge and means to insure quality patient care, rather than as a threat to nursing practice.

2. The usefulness of a QA committee is not measured by the number of problem areas uncovered, but rather by the number of corrective actions taken and problems resolved.

GUIDELINES FOR IMPLEMENTATION:

1. Evaluation criteria is determined by DON personnel.

2. Evaluation criteria are annually reviewed and revised as necessary by the area setting the standards.

3. A Nursing QA Committee will be established. Membership should include the CN, ACN, Infection Control Nurse, Nursing Methods Analyst (NMA), QA nurse, representatives from NESD, Patient Administration Division (PAD), and other areas as necessary. The committee should meet at least quarterly, preferably monthly.

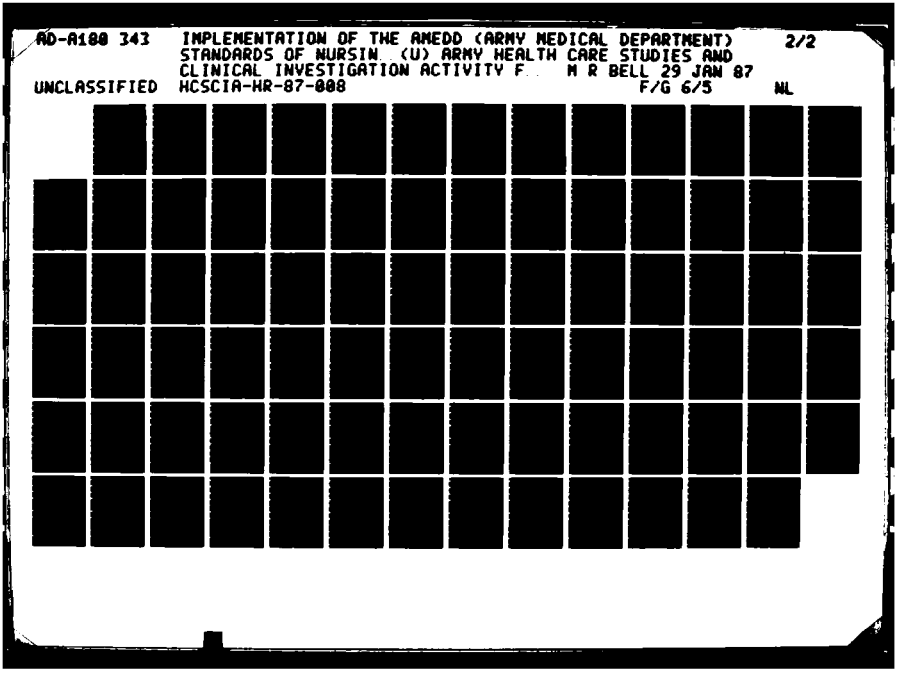
4. The Nursing QA committee reviews all unusual occurrence reports, input from members, and results of staff or patient surveys.

5. Retrospective chart audits are done by the committee members.

6. The Nursing QA committee conducts generic screening reviews to provide a general review of identifiable problem areas, e.g., cardiac arrest procedures, nursing diagnosis, medication errors, infection control.

7. Unit review is established for each nursing unit. All nurses on the unit participate, meeting monthly to review unit audits performed during the month. (See Annexes J-1 - J-3 for examples of audit forms).

8. Representatives from DON are members of all medical subcommittees. Few problems are strictly the province of one science. Nurse input into identifiable medical problems can result in mutual efforts to resolution.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IMPLEMENTATION OF THE AMEDD (ARMY MEDICAL DEPARTMENT)
STANDARDS OF NURSIN (U) ARMY HEALTH CARE STUDIES AND
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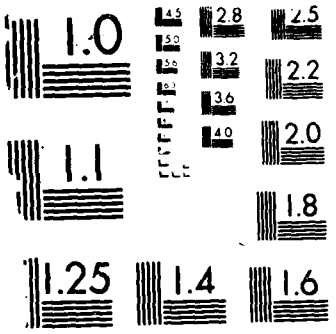

MICROCOPY RESOLUTION TEST CHART

GUIDELINES FOR IMPLEMENTATION (Continued):

9. NESD representative actively involved in quality assurance. NESD has the opportunity to identify problem areas through interest surveys.

10. Appropriate credentialling and accountability criteria developed for specialty care areas (e.g., ICU, nurse practitioners, etc.) are reviewed by the Nursing QA committee.

11. Corrective actions of local nursing unit deficiencies are carried out by the local unit personnel. Nursing QA committee representatives are notified, in writing, of the results; records of corrective actions are maintained by the committee.

12. Deficiencies whose scope or intensity prove too serious for unit action should be forwarded through channels to the Nursing QA committee and CNO for action.

GUIDELINES FOR EVALUATION:

	YES	NO
1. Written evaluation criteria are established.		
2. Evaluation criteria are reviewed annually, and revised as necessary.		
3. A Nursing QA Committee has been appointed, meeting at least quarterly.		
4. All unusual occurrence reports and surveys are reviewed by the Nursing QA committee.		
5. Quarterly retrospective chart audits are completed by the Nursing QA committee members.		
6. Generic screening is conducted quarterly on identifiable problem areas.		
7a. Peer review is actively conducted on each nursing unit.		

GUIDELINES FOR EVALUATION (Continued):

YES NO

7b. Monthly concurrent unit audits are completed.

7c. The unit group meets monthly to discuss audit results.

8. There is Department of Nursing representation on all medical subcommittees.

9a. NESD personnel are represented on the Nursing QA committee.

9b. NESD plans programs to address identified problem areas.

10. Specialty areas (e.g., ICU) have established credentialling requirements which have been reviewed by the Nursing QA committee for approval.

11. All identified deficiencies have correction actions documented in nursing unit and departmental QA files.

RESPONSIBILITIES:

NURSING SCIENCE DIVISION, USA AHS
OFFICER BASIC COURSE

1. Introduces concept of QA, Risk Management, and Peer Review to new ANC officers.

2. Stresses individual responsibility and accountability.

MTF NURSING EDUCATION AND STAFF DEVELOPMENT

1. Actively participates on QA committee.

2. Conducts quarterly surveys of nursing units to determine interest and possible problem areas.

3. Plans educational programs based on identified deficiencies.

RESPONSIBILITIES (Continued):

MTF CLINICAL HEAD NURSE

1. Insures all evaluation criteria for unit are established and/or obtained from appropriate sources (i.e., JCAH, SONP, hospital and DON policies).

2. Evaluates and updates all criteria at least annually.

3. Conducts staff inservices to clarify criteria and standards of practice as needed.

4. Establishes peer review on unit.

5. Insures peer review group conducts monthly concurrent chart reviews and meetings to review results.

6. Insures all Unusual Occurrence reports are properly completed and forwarded through channels to Nursing QA committee.

7. Conducts generic screening of unit records IAW QA policies.

8. Works with NESD and WEF to identify problem areas on unit and, when appropriate, provides instruction to alleviate problems.

9. Identifies unit deficiencies; takes corrective action to alleviate deficiencies.

10. Forwards deficiencies to Chief, Department of Nursing for action when problem is beyond scope of unit activity.

11. Develops credentialling and accountability criteria for staff, if assigned to a Specialty Care Unit, e.g., ICU.

INDIVIDUAL

1. Is aware of and understands evaluation criteria.

2. Actively participates in unit peer review.

RESPONSIBILITIES (Continued):

INDIVIDUAL (Continued):

3. Serves as nurse representative on a medical subcommittee.

4. Conducts concurrent chart auditing as required.

ANNEXES FOR STANDARD XII:

Annex J-1: "Sample Nursing Records Retrospecitve Audit Form"

Annex J-2: "Completed Example Nursing Records Audit Form (Critical Care Area)

Annex J-3: "Sample Concurrent Nursing Quality Assurance Survey - Special Care Units"

STANDARD XIII: PROFESSIONAL GROWTH

PRINCIPLE: Nursing practice provides actualization of the leadership role.

INTERPRETATION: The RN must develop leadership skills in order to implement and evaluate the standards of nursing practice. The RN is directly involved in instruction and supervision of nursing personnel who provide patient care. An individual RN is, in turn, responsible for her/his own professional growth and for fostering standards of excellence in all staff.

CLARIFICATION OF MYTHS: Leadership skill development is not limited to clinical head nurses and supervisory staff. Each nurse involved in patient care must develop certain skills. Staff development conferences should not be limited to times when problems develop.

GUIDELINES FOR IMPLEMENTATION:

1. When identifying and planning unit goals and determining methods for achievement, the head nurse should involve all RNs on the nursing unit.

2. Staffing requirements may not be determined by each unit; however, information regarding workload and staffing patterns must be maintained at the unit level. Methods for data collection must be tailored to individual units and should be communicated to all staff to assure completeness and accuracy of data. Nursing staffs need to be familiar with the importance of data collection as it relates to manpower evaluation.

3. Local MTFs should have written guidelines governing required staffing patterns for nursing units.

4. Head nurses must be able to organize staff assets in the most efficient manner to facilitate optimal patient care. Delegation of responsibilities to professional staff nurses should be made based on individual strengths and identified learning needs. Responsibilities such as inservice coordinator, charge nurse, committee membership, and maintaining time schedules should be delegated to clinical staff nurses.

GUIDELINES FOR IMPLEMENTATION (Continued):

5. Individuals identified as sufficiently skilled and knowledgeable should be selected as preceptors to orient new personnel. SOPs should be developed for unit preceptor/orientation programs. SOPs should include: criteria for selection of preceptor, preceptor's roles and responsibilities, learning objectives, and responsibilities of orientee.

6. Staff meetings should be held on a monthly basis and minutes documented for Inspector General and JCAH review. Staff meetings can be utilized to disseminate information, review and update unit goals, give positive reinforcement, and review adherence to nursing standards.

7. Quarterly developmental counselling should be accomplished by head nurses for each staff member. The head nurse should assist staff nurses in setting professional and career goals. Performance oriented counselling should be documented in writing.

8. Standards of nursing practice should be incorporated into annual performance standards and OER support forms (Annexes K through M).

9. Staff nurses should demonstrate the ability to identify their own and other's learning needs by actively participating in unit inservice programs.

10. Inservices should be given on mobilization roles of nursing personnel to identify special leadership needs.

11. Monthly staff development time should be used to facilitate professional growth. Because not all nurses have the opportunity to attend school prior to assuming new responsibilities, more experienced nurses should be used as mentors. Staff development can take the form of discussion groups for nurses. These discussions could be focused on development of leadership and managerial skills by reviewing and discussing available literature.

GUIDELINES FOR EVALUATION:

	YES	NO
1. Unit goals and methods for achievement are documented.		
2. Staffing guidelines are documented in writing.		
3. Orientation SOP includes responsibilities of preceptor and orientee, learning objectives, and criteria for selection of preceptor.		
4. Monthly staff meetings are documented.		
5. Quarterly developmental courses are conducted and documented for all personnel.		
6. Inservices are given regarding professional and paraprofessional roles in the event of mobilization.		
7. Educational opportunities are provided on the subjects of leadership and managerial skills.		
8. Performance standards reflect the SONP.		
9. OER support forms have performance goals based on the SONP.		

RESPONSIBILITIES:

NURSING SCIENCE DIVISION, USA AHS
OFFICER BASIC COURSE

1. Provides orientation to the ANC for the new graduate.

MTF NURSING EDUCATION AND STAFF DEVELOPMENT

1. Oversees identification of Department of Nursing learning needs.

RESPONSIBILITIES (Continued):

MTF NURSING EDUCATION AND STAFF DEVELOPMENT (Continued):

2. Oversees hospital orientation programs and serves as resource for preceptors from individual units.

3. Provides inservice and notice of learning opportunities that will further professional growth. Maintains current information on Army short courses and long-term schooling. Provides continuing education opportunities in middle management, goal setting, etc.

4. Looks for potential learning opportunities in the civilian setting and the hospital field setting.

5. Serves as resource for individuals setting up staff development goals.

MTF CLINICAL HEAD NURSE

1. *Identifies learning needs of staff* and provides learning experience with the assistance of NESD.

2. Develops unit goals, organizes staff in counseling, and assists them in setting individual goals.

3. Provides staff with quarterly developmental counseling and assists them in setting individual goals.

4. Identifies professional staff with potential for succession, furthering their education, and reflecting potential in the OER.

5. Encourages professional staff to seek challenging learning experiences and delegates responsibilities that will stimulate such growth.

6. Sets aside time each month for staff development.

7. Interfaces with quality assurance and/or audit committees. May assist in audits or development of audit criteria. May delegate these responsibilities to professional staff nurses.

RESPONSIBILITIES (Continued):

MTF CLINICAL HEAD NURSE (Continued)

8. Provides organized unit orientation/preceptorship program for new personnel.

INDIVIDUAL

1. Sets individual goals for professional growth that address the standards of practice, i.e., support form.

2. Identifies learning needs of peers and self; provides learning experiences to meet needs when possible.

3. Actively participates in peer review.

4. Seeks learning experiences that will improve leadership and managerial skills.

5. Provides inservices in areas of own expertise.

ANNEXES FOR STANDARD XIII:

Annex K: "Sample: Officer Evaluation Report Support Form (DA Form 67-8-1)"

Annex L: "Sample: Job Performance Planning Worksheet: Clinical Nurse, GS 0610, Gs09, 58-79 (ICU/CCU)"

Annex M-1: "Performance Standards: Clinical Head Nurse"

Annex M-2: "Performance Standards: Clinical Staff Nurse"

Annex M-3: "Performance Standards: 91C/Licensed Practical Nurse"

ANNEXES

A-1 The Clinical Interview
A-2 Interpersonal Interview Skills Guide
B Systems' Assessment and Documentation
C The Two Languages of Nursing and Medicine
D Nursing Diagnosis
E Nursing Diagnosis Do's and Don'ts
F Integrated Nursing Care Plan
G Patient Goals
H Individual Responsibilities for Documentation in the Clinical Record
I-1 Course Outline: Emergency Drugs Review
I-2 Emergency Drugs Review: Pretest and Posttest
J-1 Sample: Nursing Records Retrospective Audit Form
J-2 Completed Example Nursing Records Audit Form (Critical Care Area)
J-3 Sample Concurrent Nursing Quality Assurance Survey Form: Special Care Units
K Sample: Officer Evaluation Report Support Form (DA Form 67-8-1)
L Sample: Job Performance Planning Worksheet: Clinical Nurse, GS 0610, GS09, 58-79 (ICU/CCU)
M-1 Performance Standards: Clinical Head Nurse
M-2 Performance Standards: Clinical Staff Nurse
M-3 Performance Standards: 91C/Licensed Practical Nurse (LPN)

ANNEX A-1

THE CLINICAL INTERVIEW

	STAGE APPROPRIATE NURSING BEHAVIORS		EVALUATION
	VERBAL	NON-VERBAL	Was the interview
PREPARATORY Gather background information Organize and plan interview	Telephone and other verbal reports	Read available reports/records Organize thinking & interview plans taking into account: -patient's clinical condition, Dx -interview priorities -time constraints -personal abilities, attitudes	ADEQUATE? *Was necessary information obtained & recorded? *Was uncollected/unkown information noted as such on record? *Was the patient's anxiety reduced upon completion of the interview?
BEGINNING Greet patient Put patient at ease Provide introductory information	Greet patient sociably BY NAME Orient patient to situation; frame sequence of events Give BROAD OPENING Verbally acknowledge communications	Nurse's professional appearance & manner essential Observe patient's/family's behavior TOUCH: Handshake at beginning, other as appropriate Actively listen -maintain appropriate eye contact -nod as appropriate	APPROPRIATE? *Were therapeutic behaviors utilized as indicated? Were they used more frequently than non-therapeutic behaviors? *Was irrelevant information tactfully excluded from the interview?
WORKING Gather information Decrease patient's anxiety	Be flexible enough to follow client's lead or focus as indicated Use techniques skillfully -Restating (repeating) -Reflecting (return responsibility for interpretation/ decision to patient) -Clarifying/Validating -use questions: open-ended direct avoid leading questions	Use space skillfully -judge best balance of distance/ closeness -be conscious of posture (sitting, standing, other) -provide privacy Use silence skillfully Be aware of voice volume, rate, tone Use professional judgment about recording information during session	*Were interruptions tactfully managed? EFFECTIVE? *Was the desired nurse-patient relationship established? *Were steps taken to decrease the patient's anxiety?

ANNEX A-1

THE CLINICAL INTERVIEW

	STAGE APPROPRIATE NURSING BEHAVIORS		EVALUATION
	VERBAL	NON-VERBAL	
WORKING (Continued	-use "I understand you to say ...Is that correct?" Make observations Give information	In family interviews, use clinical judgment about who should report information	*Was the data recorded in a clear and accurate manner?
TERMINATING Closing Gather background information Organize and plan interview	Indicate time limitations in advance		EFFICIENT? *Was the interview situation structured to prevent unnecessary interruptions? *Was the interview completed in an organized fashion and within available time?
RECORDING		Condition/situation appropriate information on correct form and in correct format	*Was only relevant information recorded in a clear, concise, and organized fashion?

ANNEX A-2

INTERPERSONAL INTERVIEW SKILLS GUIDE

INSTRUCTIONS: For each item listed below the student will be rated and should rate himself/herself as follows:

1=Omitted
2=Poorly Done
3=Adequately Done
4=Well Done
5=Exceptionally Done
0=Not Applicable

SELF RATING	OBSERVER RATING	
		INTRODUCTION
_____	_____	Introduces self to/or greets patient in a respectful and friendly way.
_____	_____	Explains role of self.
_____	_____	Defines and clarifies for patient scope of services practitioner can provide.
_____	_____	Discusses goals of the interaction and relationship.
		FACILITATIVE BEHAVIOR
_____	_____	Seats her/himself in an appropriate manner in relation to the patient.
_____	_____	Pursues investigation of relevant verbal cues.
_____	_____	Follows up on nonverbal cues.
_____	_____	Effectively and smoothly moves from one major area of questioning to another.
_____	_____	Expresses interest and warmth toward patient.
_____	_____	Notes degree of eye contact.
_____	_____	Tactfully questions patient about inconsistencies.
_____	_____	Avoids use of medical terminology.
_____	_____	ENSURES patient understanding.
_____	_____	Uses appropriate interventions to encourage patient to focus on major areas of concern.

SELF RATING	OBSERVER RATING	
		FACILITATIVE BEHAVIOR (Continued):
_____	_____	Answers patient's questions appropriately.
_____	_____	Summarizes what patient has said to clarify for both patient and practitioner.
_____	_____	Allows expression of patient's feelings.
_____	_____	Conveys understanding and/or empathy of patient's feelings.
_____	_____	Offers concrete guidance where appropriate.
_____	_____	Provides appropriate information to patient.
_____	_____	Avoids leading questions.
_____	_____	Avoids unnecessary repetition.
_____	_____	Behavior and manner appropriate during patient interview.
_____	_____	Provides patient opportunity for reflective silences.
_____	_____	Allows patient to complete statement.
_____	_____	Clinician's comfort allows for exploration of sensitive areas.
_____	_____	Avoids questions that are threatening to patient and draws out such information more tactfully.
_____	_____	Uses vocabulary consistent with patient's education and background.
_____	_____	Clinician avoids imposing her/his bias on patient in a non-therapeutic manner.
		TERMINATION
_____	_____	Indicates a few minutes in advance when interview is to be terminated.
_____	_____	Summarizes interview and patient progress and asks if summary is acceptable.
_____	_____	Gives patient opportunity to ask questions and present opinion about interview and his/her progress.

INTERPERSONAL INTERVIEW SKILLS GUIDE (Continued):

SELF RATING	OBSERVER RATING	
		TERMINATION (Continued):
_____	_____	Indicates how patient can have access to care and explains process of that (and other) institutions.
_____	_____	Clearly states to patient what is to happen next.
_____	_____	Re-emphasizes emotional support and concern.
_____	_____	Clearly specifies plans for future interviews.

SOURCE: OKEN, S. et. al. Interpersonal skills course. Unpublished manuscript. The Johns Hopkins University School of Health Services, Health Associate Program, Baltimore, MD 1977.

ANNEX B

Systems' Assessment and Documentation

I. Neurological (Neuro)

A. Orientation: Oriented to person, place and time; or disoriented confused, answers questions inappropriately.

B. Level of consciousness: alert, drowsy, lethargic, comatose. Responses - to verbal stimuli (adequate or inadequate), to painful stimuli (with purposeful movements or non-purposeful), lethargic, but can answer questions when stimulated. Ability to follow commands - simple commands.

C. Describe abnormalities in detail.

II. Eyes, Ears, Nose and Throat (EENT)

A. Eyes: Pupils equal, reactive to light and accommodate. Vision - no difficulty, wears glasses, blindness - bilateral or unilateral.

B. Ears: Hearing - hard of hearing, deafness in both or either ear, use of hearing aid. Any drainage from ears - color, amount, consistency.

C. Nose: *Rhinorrhea? - color, amount,* consistency. Nasal surgery - swelling, packing, drainage, etc.

D. Throat: Sore throat, difficulty swallowing, appearance on inspection, swollen lymphs.

E. Document any abnormalities in detail.

III. Cardiovascular (CV)

A. Skin: Color - pallor, cyanosis; jaundice, change in pigmentation, cyanosis of nailbeds and lips. Temperature. Tugor. Moisture - dryness diaphoretic, oily, clammy.

B. Observation of peripheral circulation: Pulses (femoral, radial, pedal) - palpable, equal bilaterally, full and regular, weak, irregular, pulse deficit. Edema - degree of pitting, location, bilateral or unilateral, weight gain or loss if a daily weight. Color and warmth of extremities.

C. IV's: Contents of bottle hanging, bottle number, rate of redness edema, site care, tubing change.

III. Cardiovascular (CV) (Continued):

D. Vital signs: BP, pulse, apical pulse. Regular or irregular heart rate. Telemetry pattern and strip if applicable.

E. Pain: Location, radiation, duration, type of pain - sharp, dull, ache intermittent, continuous. What relieves pain, any meds given, document results obtained from meds.

F. Intrathoracic tubes and or dressings: Dresssing - location, drainage, amount, type, color consistency, dressing change. Tubes - patency, drainage, etc.

G. Pertinent Lab Results: Electrolytes, EKG, X-ray, Cardiac Enzymes, etc.

IV. Pulmonary (Pulm)

A. Respirations: Rate, regularity, effectiveness, depth, abdominal breather, use of accessory muscles, etc. Chest movement associated with respirations, symmetrical or asymmetrical.

B. Breath Sounds: Clear to auscultation, rales, rhonchi, wheezes, etc. Describe in detail which lobes have adventitious breath sounds (BS), anterior or posterior auscultation.

C. Oxygen: % given, liters/min., method of administration (mask, cannula, etc.) continuous or PRN.

D. Cough or suctioning: Cough--productive or non-productive, do breath sounds change after cough? Suctioning - frequency, color, amount, consistency. Sputum specimens needed or obtained. Hemoptysis.

E. Respiratory therapy treatments or diagnostic tests: Type of treatment or test, frequency, results. Pulmonary Function Studies (PFS), Arterial Blood Gases (ABGs) etc.

V. Gastrointestinal (GI)

A. Abdomen: Auscultation - bowel sounds present, hypoactive, hyperactive, which quadrants. Palpation - firm, soft, tender-where, distended abdominal girth if applicable.

B. Bowel Movements: Frequency, consistency, stool specimens, use of laxative or prep for X-ray tests.

C. Nausea or vomiting - any meds given. Appetite - % of meal taken, type of diet, NPO for testing or OR.

V. Gastrointestinal (GI) (Continued):

D. Dressing and/or drains: Amount of drainage - type, color, consistency. Dressing - type, any drainage, dressing change, appearance of incision, etc. NG tube - patency, irrigation, suction - high or low Gomco, description of drainage - coffee grounds, etc.

VI. Genitourinary (GU)

A. Urination: Continent, incontinent, use of bedpan, ambulates to bathroom, foley catheter - irrigation, catheter care, adequate or inadequate output, frequency, urgency, nocturia, pain or burning, hematuria, color, sediment, U/A needed or obtained.

B. Vaginal Drainage: Type, amount, color, consistency, cramping, last menstrual period (LMP) if applicable, etc.

C. Surgery - describe in detail.

VII. Integumentary (Integ.)

A. Note any ulcerations, open sores, contractures, breakdown, etc. Decubitus care--turning, skin care, egg crate or air mattress. Describe appearance and effectiveness of treatment.

VIII. Musculoskeletal (Musc.-skel.)

A. Movement: Moves all extremities purposefully or non-purposefully, Range of Motion (ROM) muscle strength, history of arthritis, fractures, joint replacements, surgeries, back pain, etc.

B. Foot Surgeries: Dressing - location, drainage, edema, dressing change Activity - ambulatory with Reese shoes, walker, crutches, non-ambulatory, etc. Pain - medications, ice, elevation, etc.

IX. Psycho-Social (Psych)

A. Adjustment to hospitalization and illness; manner, mood, behavior (restless, depressed, anxious, etc.), relation to persons around them (cooperative, angry, etc).

X. Instructional Needs

A. Type of instruction needed or ordered: Hypertension, Diabetes Mellitus, myocardial Infarction, Chronic Obstructive Pulmonary Disease. Post-op, tests to be run, dietary, etc.

B. Plan for carrying out teaching - describe in detail.

ANNEX C

"THE TWO LANGUAGES OF NURSING AND MEDICINE"

A. NEUTRAL PHRASES	NURSING	MEDICINE
1. Visit to a patient home	Home visit	House call
2. Methods of effecting patient care	Nursing Care Plan	Medical regimen
B. PHRASES THAT INDICATE DIFFERENT PROFESSIONAL ORIENTATIONS	**NURSING**	**MEDICINE**
1. Central questions of the profession	What are the patient's problems? How is he coping with them? What help does he need?	What is the patient's diagnosis? What treatment does he need?
2. Phenomena dealt with	Discomfort	Symptom
	Patient concern	Disease
	Vision	Eyes
	Mobility	Musculoskeletal and neurological systems
	The patient with tuberculosis	Diseases due to Mycobacteria
3. Professional specialty areas	Maternal-Child Health	Obstetrics and Pediatrics
4. Process of improving the patient's future health	Promotion of health and well-being Health care supervision	Preventive medicine
5. Expressing esteem for the	He really knows his patients	He really knows his medicine
6. People served	Patient	Clinical material; Teaching material; Cases
7. People served who are especially valued	Good/nice/cooperative patients; Patients who really need help	Fascinating patients; Good clinical material; Great cases
C. PHRASES WHICH REFLECT PROFESSIONAL TERRITORIALITY	**NURSING**	**MEDICINE**
1. Evaluate process in patient care	Gather or collect information; take a nursing history	Take a history
	Assess	Diagnose
	Physical assessment	Physical diagnosis
	A problem	A daignosis

ANNEX D

NURSING DIAGNOSIS

REFERENCE	
G	Activity Tolerance, Decreased (Specify Level)
K	Adjustment to illness, impairment of significant others
G	Airway Clearance, Ineffective
K,G	Anxiety, Mild
K,G	Anxiety, Moderate
K,G	Anxiety, Panic
K,G	Anxiety, Severe
K	Body Fluids, Excess
G	Body Image Disturbance
G,K	Bowel, Elimination, Alterations in: Constipation
G,K	Bowel Elimination, Alterations in: Diarrhea
K	Bowel Elimination, Alterations in: Impaction
G,K	Bowel Elimination, Alterations in: Incontinence
G	Breathing Patterns, Ineffective
G,K	Cardiac Output, Alterations in: Decreased
K	Circulation, Interruption of
G	Cognitive Impairment, Potential
G,K	Comfort, Alterations in: Pain
K	Communication, Impaired Verbal
K	Consciousness, Altered Levels of
K,G	Coping Family: Potential for Growth
G	Coping, Ineffective Individual
G	Coping, Ineffective Family: Compromised
G	Coping, Ineffective Family: Disabling
K	Coping Patterns, Family, Ineffective
K	Coping Patterns, Individual, Maladaptive
G	Decubitis Ulcer
G	Depression, Reactive (Situational)
G	Diversional Activity, Deficit
G	Fear (Specify Focus)
G,K	Fluid Volume Deficit, Actual (1,2)
K	Fluid Volume Deficit, Potential
K	Functional Performance, Variations in
K	Functional Performance, Variations in: home maintenance management impaired
G	Gas Exchange, Impaired
K	Grieving
G	Grieving, Anticipatory
G	Grieving, Dysfunctional
G	Health Management Deficit, Total
G	Health Management Deficit (Specify)
G	Home Maintenance Management, Impaired (Mild, Moderate, Severe, Potential, Chronic)
G	Independence-Dependence Conflict, Unresolved
G	Infection Potential for
K	Injury, Potential for

REFERENCE	
K	Injury: Susceptibility to Hazard
G	Joint Contractures, Potential
G	Knowledge Deficit (specify)
K	Knowledge, Lack of (Specify as to area)
K	Mobility, Impairment of
G	Mobility, Impaired Physical (Specify Level)
K	Noncompliance
G	Noncompliance (specify)
G	Noncompliance Potential (specify
K	Nutrition, Alterations in: Changes Related to Body Requirement
G,K	Nutrition, Alteration in: Less Than Body Requirements
G,K	Nutrition, Alterations in: More Than Body Requirements
G	Nutrition, Alterations in: Potential For More Than Body Requirements
G	Parenting, Alterations in
K	Parenting, Alterations in: Actual
G,K	Parenting, Alterations in: Potential
G	Personal Identity Confusion
G	Poisoning, Potential for
G	Rape-Trauma Syndrome
G	Rape-Trauma Syndrome: Compound Reaction
G	Rape-Trauma Syndrome: Silent Reaction
K	Respiratory Dysfunction
G	Self-Bathing-Hygiene Deficit (Specify Level)
G	Self-Care Deficit (Specify level: Feeding, Bathing/ Hygiene, Dressing/grooming, Toileting
K	Self-Concept, Alteration In: Body Image, Self-Esteem, Role Performance, Personal Identity
K	Self-Concept, Disturbance in
G	Self-Dressing-Grooming Deficit (Specify Level)
G	Self-Esteem Disturbance
G	Self-Feeding Deficit (Specify Level)
G	Self-Toileting Deficit (Specify Level)
G,K	Sensory Perceptual Alterations
K	Sexuality, Alteration in Patterns of
G	Sexual Dysfunction
G	Short-Term Memory Deficit, Uncompensated
G,K	Skin Integrity, Impairment of: Actual
G,K	Skin Integrity, Impairment of: Potential
G	Sleep Pattern Disturbance
K	Sleep/Rest Activity, Dysrhythm of
G	Socialization, Alterations in
G	Social Isolation
G	Spiritual Distress (Distress of the Human Spirit)
K	Spirituality: Spiritual Concerns
K	Spirituality: Spiritual Despair
K	Spirituality: Spiritual Distress
G	Stress Incontinence
G	Suffocation, Potential for
K,G	Thought Processes Impaired
K,G	Tissue Perfusion, Abnormal, Chronic

REFERENCE

G	Translocation Syndrome
G	Urinary Elimination, Alteration in Patterns
K,G	Urinary Elimination, Impairment of: Incontinence
K,G	Urinary Elimination, Impairment of: Retention
G	Verbal Communication, Impaired
G	Violence, Potential for

NOTE: When using any of these nursing orders be sure to add the cause, i.e.: "Activity intolerance - secondary to cast"; or "secondary to knee injury"; or "secondary to immobilization", etc.

"Anxiety - secondary to hospitalization"; or "secondary to disease process;" or "secondary outcome of surgery", etc.

References:

Kim, M. J., McFarland, G. K., McLane, A. M. (Eds.) (1984). Pocket guide to nursing diagnoses. St. Louis: CV Mosby Company. This reference contains nursing diagnoses approved for testing at the 5th National Conference on Classification of Nursing Diagnoses, April, 1982.

Gordon, M. (1982) Manual of nursing diagnosis. New York: McGraw-Hill Book Company. This reference includes nursing diagnoses currently approved at the national conference (1982) in addition to diagnostic categories not accepted for clinical testing, but which proved useful in care planning.

ANNEX E

NURSING DIGANOSIS DO'S AND DONT'S

DO:

1. Describe patient problems which require NURSING INTERVENTION.
2. Focus on the PATIENT'S RESPONSE to a health problem rather than on the disease or disorder itself.
3. Develop POTENTIAL as well as ACTUAL problems.
4. REVISE the nursing diagnosis as the patient's condition changes.
5. PRIORITIZE your nursing diagnoses.
6. Utilize BOTH PROBLEM AND ETIOLOGY PHRASES of the nursing diagnoses.
7. Use the list of accepted nursing diagnoses.

DON'T

1. Reiterate the medical diagnoses as the nursing diagnoses.
2. Use patient needs as the nursing diagnoses.
3. Use signs and symptoms as the primary thrust of the diagnoses if there is a better way.
4. Make legally inadvisable statements.
5. Describe nursing tasks in the nursing diagnoses.
6. Duplicate the same information in the problem and etiology phrases.
7. Show environmental factors as the problem phrase of the diagnosis.
8. Describe a healthful response.

REFERENCES: Bockrath, M. (1982) Your Patient Needs Two Diagnoses- Medical and Nursing. Nursing Life, 5 (2), 29-34.

Dossey, B. and Guzzetta, C. (1981) Nursing Diagnosis. Nursing 81, 11 (6) 37-40.

ANNEX F

INTEGRATED NURSING CARE PLAN

ASSESSMENT Nsg hx/phys exam data	ANALYSIS Nursing Diagnoses	PLANNING Patient Goals	IMPLEMENTATION Nursing Orders	EVALUATION Nursing Notes
Insomnia during stressful situations. Unable to sleep without a night light on.	Potential sleep pattern disturbance related to stress of hospitalization and darkness of room. 1	Will sleep soundly at night during hospitalization.	a. Evaluate need for/offer sleeping medication rather than waiting for patient to ask for it. b. Ensure that night light is left on in room during night.	
History of fluid retention X 6 years. Takes HCTZ 50 mg q.d. BP 120/80. Serum K 4.2 mEq/L.	Potential fluid volume excess related to hx of fluid retention. 2	Will exhibit no excess fluid retention postoperatively.	a. Assess face, extremities Q shift for edema. b. Document I&O for 24 hr postoperatively and evaluate Q shift for imbalances. Continue recording I&O as indicted. c. Weigh daily and record	
Inspiratory wheeze RLL. Has smoked 2 PPD X 10 years. Occasional sinusitis, bronchitis. No previous general anesthesia.	Potential postoperative respiratory dysfunction related to history of fluid retention and preoperative RLL wheeze. 3	Will demonstrate uncompromised respiratory status postoperatively.	a. Encourage postoperative stir-up regimen Q2H until fully ambulatory. b. Observe and critique 1st 2 post-op uses of inspirometer. c. Remind to use inspirometer 10 min of every hour while awake. Reassess need for inspirometry when fully ambulatory. d. Ausculate lungs (especially RLL) Q shift for abnormal breath sounds. (0800, 1600, 2200 hours)	
Last bowel movement 4 days prior to adm. Usually QOD. No laxative use diet change.	Alteration in bowel elimination (constipation) due to unknown etiology.	Will have bowel movement within 48 hour postoperatively.	a. Assess bowel elimination status BID: 1000 and 2200. b. Encourage fluids IAW orders.	

ANNEX G

PATIENT GOALS

**PATIENT GOAL STATEMENT ARE:

Derived from identified nursing diagnoses and higher level goals.
Written in terms of desired PATIENT accomplishments.
Objective.
Measurable by observation.
Mutually established.
Realistic, reasonable, and attainable.
Communicated with the patient and other nursing personnel.
Understandable to all personnel working with the patient.

**A CORRECT PATIENT GOAL STATMENT:

Starts with an ACTION VERB.
States a TASK to be accomplished.
Specifies CONDITION/STANDARDS to be met.
Sets a TIME FRAME for accomplishment.

**EXAMPLES OF ACTION VERBS

adjust	deduce	group	perform	say
align	defend		pick	select
alter	define	handle	plan	send
analyze	delineate		plot	set
annotate	demonstrate	identify	point	show
arrange	describe	illustrate	position	simulate
apply	designate	imitate	predict	sit
assemble	detect	index	prepare	solve
assist	determine	indicate	prescribe	sort
	develop	initiate	present	specify
build	devise	interpret	produce	state
	diagram	institute	program	substantiate
calculate	differentiate	instruct	propose	supervise
calibrate	direct	issue	prove	supply
catalogue	discriminate	itemize	provide	sustain
change	discuss			
choose	display	lead	quote	tabulate
cite	distinguish	list		tally
clarify	draw	locate	recall	teach
collect			recite	tell
combine	enumerate	maintain	recognize	test
compare	estimate	make	recommend	transcribe
compile	evaluate	manipulate	record	translate
complete	execute	mark	recover	turn
compose	exhibit	match	regulate	
compute	explain	measure	remove	use
conclude	expose	move	repair	
conduct	express		repeat	walk
construct		name	replace	write
contrast	file		report	
control	fix	operate	respond	
convert		organize	review	
coordinate	gather	outline	revise	
copy	give			

ANNEX H

INDIVIDUAL RESPONSIBILITES FOR DOCUMENTATION IN THE CLINICAL RECORD

1. GENERAL

a. Only black or blue ink will be used in clinical records. (*)

b. Erasures are prohibited. Errors will be lined through with a single line, the initials of the person making the entry will be placed above the error, and the correct entry will follow the lined-out portion. (White correction fluid will not be used. (*)

c. A staff signature/initial verification list will be placed in each patient's chart. This list should appear on DA Form 4700, but can be on SF 510. (*#)

d. Use only authorized abbreviations. (#)

e. Patient identification/addressograph stamp will be placed in the designated space on each document in the clinical record. (*)

2. DOCTOR'S ORDERS (DA Form 4256)

a. The prescriber will enter the data and time the order is written. (*)

b. Use of the entry "Routine Orders" to refer to a set of predetermined actions is prohibited. (*)

c. Each physician's order must be accounted for separately by the clerk or nurse who transcribes it. Initials of the clerk or nurse and the time to the far right of the order implies that the order has been transcribed and the appropriate action taken. (*)

d. Overprinted orders on DA Form 4256 or orders preprinted on DA Form 4700 are acceptable if they are signed by the prescriber and accounted for by the clerk or nurse as with written orders. (*#)

e. Verbal orders will be confined to emergency or STAT situations will write the order followed by the notation "Verbal Order", the physician's name, and the nurse's payroll signature. Verbal orders will be countersigned by the physician ASAP after the emergency. (*)

f. Telephone orders will be kept to a minimum, accepted only by an RN (with 3d party verification when possible), and countersigned by the prescribed within 24 hours. (*)

g. To discontinue a medication or treatment, a stop order must be written and signed by the physician, and accounted for as in para 2c above. Automatic stop orders will be governed by local policy. (*)

3. NURSING ASSESSMENT AND CARE PLAN (DA Form 3888 and 3888-1)

a. Forms are to be completed for each patient identified by the RN. The history and assessment must be completed within 48 hours of admission to fulfill their purpose, and ideally, should be completed upon admission. The RN is responsible for preparation of these forms. (*+)

b. Assessment includes at a minimum: (+)

(1) Nursing History (DA Form 3888)
(2) Nursing Assessment (DA Form 3888-1)

(a) general appearance
(b) age, sex, and race
(c) height and weight
(d) physical disabilities
(e) skin condition
(f) behaviors indicative of mental-emotional status
(g) history and review of systems as appropriate for planning care

c. Problems (nursing diagnoses) will be numbered to correspond with planned nursing interventions (nursing orders). (*)

d. Expected outcomes (patient goals) will be identified as long (L) or short (S) term goals. (*)

e. The Nursing Care Plan will be revised as additional data are obtained or as the patient needs change. (+)

f. When a patient is received as a transfer-in from another unit, the receiving RN will review the nursing assessment (and care plan) and record this action in the Nursing Notes. (+)

4. THERAPEUTIC DOCUMENTATION CARE PLANS (TDCP)(DA Forms 4677 and 4678)

a. Enter all administrative data as indicated on the forms: (*)

(1) month and year
(2) allergies
(3) diagnoses - primary and corrected
(4) page number

b. The individual who transcribed an order to the TDCP must initial to the left of the order. A clerk must use the top line; a nurse must use the bottom line. (*)

c. Nursing orders will be signed by the nurse initiating the orders. (*)

d. When an order is discontinued, write across the remaining grids "DC/date/initials". THIS IS REQUIRED. The use of yellow highlighter over the order and the grids is OPTIONAL and is to be used in addition to the written notation. (*)

e. Medical or nursing orders which are not carried out as ordered will be indicated by a circle in the appropriate blank of the TDCP. Such a measure must be accompanied by a corresponding nursing note which gives the details of the omission or deviation. (*#)

f. Copied orders: (*)

(1) A double line will be drawn beneath the old orders.
(2) The heading will include the date, "Copied", and the new action dates.
(3) Show the date of the original order, the copying nurse's initials, and the original prescriber's name.

g. Initial grids AFTER accomplishment of the task. The TDCP is a legal document which states that each order was in fact carried out. (*#)

h. Single actions: (*)

(1) Enter the date and time to be accomplished, if known. "On Call" is acceptable.
(2) Enter the exact time the order was accomplished and initials.

i. PRN medications (particularly controlled substances and those with an automatic stop) should show both the order and the expiration date. (*)

j. Use SPECIFIC action times whenever possible, rather than D-E-N.

k. D-E-N better than B-L-D for diet orders.

l. Use of "Action Times" in the lower right corner is optional. (*)

5. NURSING NOTES (SF510)

a. "...it is essential that all entries contain significant and pertinent data relative to nursing care." (*)

b. Nursing notes should contain:

(1) objective observations of the patient's condition including physical and mental status, symptoms, response to procedures, or changes;(*)
(2) the patient's unique status, needs, responses, problems, capabilities, and
(3) the degree of goal achievement or non-achievement.(+)

c. A Nursing note entry is required in the following circumstances:

(1) Admission. This note will contain at a minimum: (*)

(a) date and time of admission
(b) manner of admission
(c) symptoms and pertinent observations
(d) allergies

(2) For each narcotic, STAT, or PRN medication. These entries will contain: (*)

(a) time
(b) medication (amount and route #)
(c) indication/reason for administration
(d) assessment of effectiveness

(3) For each diagnostic or therapeutic procedure, special nursing procedure, or unusual occurrence. These entries will contain: (*)

(a) time
(b) name of procedure
(c) who performed it
(d) what was done (briefly)
(e) condition/reaction of patient before, during, and after

(4) According to patient categorization. Entries are required: (*)

(a) Q Shift on Category I (Intensive Care) and Category II (Moderate Care)
(b) Q 24 Hours on Category III (Minimal Care)
(c) Q Week on Category IV (Self Care)

(5) On discharge if no discharge summary (DA Form 4700 is in use. (*) This note will contain:

(a) date, time, and manner of discharge (*)
(b) concise summary of instructions given and verbalization or indication that the instructions were understood by the patient, family, and/or significant other (+)

d. SOAP format is optional. (#)

e. A date must appear on each page, and all entries must indicate the time of entry. (#)

f. All entries will be signed with the individual's payroll signature. (*)

6. TPR GRAPHIC (SF 511)

a. Use a solid line to connect systolic and diastolic blood pressure readings. (*)

b. Connect temperature dots and pulse circles to show sequential progress. (*)

c. If temperature is other than oral, indicate rectal (R) or axillary (A) by the temperature reading. (*)

7. PATIENT DISCHARGE PLAN (DA Form 4700)

a. This overprinted form will be used for discharge planning, for documenting patient preparation for discharge, and for providing the patient with written instructions to take with him or discharge. (*)

b. The form should be completed in duplicate. The original becomes a part of the permanent clinical record, and the copy if reviewed with the patient and is kept by him. (*)

c. Information on this form should be pertinent, factual and written in language understood by the patient. (*)

REFERENCES AND KEY:

* AR 40-407 1 Nov 79, Nursing Records and Reports (w/C2 15 Apr 82)
+ DA Pam 40-5, Nov 81, AMEDD Standards of Nursing Practice
# AHS Programmed Instruction 61-290-344-1, Nursing Records and Reports

ANNEX I-1

COURSE OUTLINE

"EMERGENCY DRUGS REVIEW"

OBJECTIVES

1. Match various potentially fatal cardiac dysrhythmias with their appropriate regimens of medication.

2. Identify the safe and effective methods of preparing and administering 13 common "crash cart" medications.

3. List the implications of magnesium sulfate.

4. Identify the alpha and beta adrenergic drug effects desired in treating severe asthma/anaphylactic shock.

5. Identify the dosage in the medication choice for a comatose client.

COURSE CONTENT:

I. THE NEED TO KNOW

A. The five "rights" of giving medications

B. Commonly used emergency drugs with specific dysrhythmias

II. CARDIAC RESUSCITATION

A. Scenario of a cardiac arrest

1. ABC's of CPR
2. Basic physiology of an arrest victim
3. Four fatal dysrhythmias

a. third degree heart block
. frequent PVC's and ventricular tachycardia
c. ventricular fibrillation
d. asystole

B. Some common drugs and their:

1. Indications
2. Actions
3. Side effects and incompatibilities
4. Nursing implication
5. Dosage regimens, including children

a. sodium bicarbonate
b. epinephrine
c. lidocaine

d. atropine
e. isuprel
f. calcium chloride
g. inderal
h. pronestyl
i. dopamine
j. dilantin (antiarrhythmic and anticonvulsant)

III. ECLAMPSIA/TOXEMIA OF PREGNANCY

A. Brief physiology of eclampsia

B. Magnesium sulfate

1. Effects
2. Special assessments and precautions
3. Dosage regimens
4. IV calcium as antidote

C. Nursing implications

IV. ACUTE ASTHMA/ANAPHYLAXIS

A. Epinephrine subcutaneously

1. Alpha and beta adrenergic effects
2. Dosage, route

B. Nebulized Isuprel

C. Benadryl - IV antihistaminic

D. Nursing implications

V. THE DIABETIC COMATOSE PATIENT

A. Quick assessment

B. 50% Glucose - to give, or not to give?

C. Rationales and follow-up care

D. Nursing implications

ANNEX-I-2

EMERGENCY DRUGS REVIEW:

PRETEST-POST TEST

1. Lidocaine as an antiarrhythmic agent is commonly used in the emergency treatment of:

   a. ventricular arrhythmias.

   b. atrial arrhythmias.

   c. supraventricular arrhythmias.

   d. hypotension.

2. The usual adult dosage for IV bolus administration of Lidocaine is:

   a. 5-10 mg.

   b. 50-100 mg.

   c. 150 mg.

   d. 200 mg.

3. The onset of action of lidocaine per IV bolus occurs within _____ minutes, with duration of action for a single dose to be_____minutes.

   a. 10, 50-60.

   b. 8, 40-50.

   c. 6, 20-30.

   d. 2, 10-20.

4. Lidocaine may cause toxicity in patients with:

   a. hypersensitivity to local anesthetics.

   b. liver disease.

   c. congestive heart failure.

   d. all of above.

5. Adverse reactions to injections of Lidocaine Hydrochloride include:

   a. drowsiness, dizziness, apprehension, euphoria.

   b. sensations of heat, cold or numbness.

   c. twitching, convulsions, unconsciousness, respiratory depression and arrest.

   d. hypotension, cardiovascular collapse, bradycardia.

   e. all of above.

6. If atropine sulfate is given IV route for treatment of bradycardia or bradyarrhythmias, the usual dose is:

   a. 0.5 - 1.0 mg IV push, repeated Q5 min to maximum of 2 mg.

   b. 1.0 mg IV push x 1 dose.

   c. 0.5 mg IV push, repeated Q5 min to maximum of 5 mg.

7. Which of the following are not actions of Atropine?

   a. increases the heart rate.

   b. decreases salivation.

   c. decreases bronchial secretions.

   d. anti-inflammation.

8. Which of the following are <u>not</u> known side effects of Atropine?

   a. coloring urine orange.

   b. dry mouth.

   c. blurred vision.

9. Sodium Bicarbonate is used to correct:

   a. bradycardia.

   b. metabolic acidosis.

   c. metabolic alkalosis.

   d. decreased cardiac output.

10. When giving sodium bicarbonate you should mainly monitor:

    a. blood gases and blood pH.

    b. urine protein.

    c. cardiac output.

    d. deep tendon reflexes.

11. Epinephrine is the drug of choice for treating:

    a. hypertension.

    b. cerebral arteriosclerosis.

    c. anaphylactic shock.

12. Epinephrine exerts its main action upon:

    a. the heart.

    b. the blood vessels.

    c. smooth muscle of the body.

    d. a and c.

    e. all of above.

13. Epinephrine activates:

    a. alpha receptors.

    b. beta receptors.

    c. both alpha and beta receptors.

    d. neither alpha or beta

14. Epinephrine does all of the following except:

    a. relax smooth muscles in the respiratory tract.

    b. decrease cardiac irritability.

    c. stimulate the myocardium to increase the force of contractions.

    d. act as a vasoconstrictor on peripheral arterioles.

15. In emergency cardiac care, dopamine is primarily indicated for:

a. cardiogenic shock.

b. acute hypertensive state.

c. ectopic beats.

d. tachyarrhythmias.

16. Adverse effect of Dopamine include:

A. ectopic beats.

B. nausea and vomiting.

C. acute hypertension.

D. tachyarrhythmias.

a. All of above
b. A,D
c. B,C
d. None of above

17. When giving Pronestyl IV, Epinepherine:

a. should be kept easily accessible in case of failing circulatory system.

b. need not be accessible because it is of no help in cases of failing circulatory system.

c. is contraindicated in failing circulation system because it may aggravate an existing arrythmia.

18. Pronestyl:

a. is chemically related to procaine but with longer duration of action.

b. depresses irritability of myocardium.

c. is used in treatment of ventricular and auricular arrhythmias.

d. all of above.

19. Which of the following medications would contraindicate the use of CaCl?

    a. Digoxin.

    b. $MgSO_4$.

    c. Xylocaine.

    d. Nafcillin.

20. When KCl is administered parenterally, it is important for the nurse to know the:

    a. age of the patient.

    b. rate of flow ordered by MD.

    c. dx of patient.

    d. solution to be used as vehicle.

    e. sex of patient.

INSTRUCTIONS: Circle the number on the scale which most clearly corresponds with your opinion on the topic presented and the course objectives.

"EMERGENCY DRUG REVIEW"	RATING SCALE: STRONGLY DISAGREE	DISAGREE	AGREE	STRONGLY AGREE
1. The material was easy to comprehend.	1	2	3	4
2. The subject was presented in a clear concise manner.	1	2	3	4
3. This class increased my knowledge of the subject matter.	1	2	3	4
4. During an emergency, I will be able to apply the information presented.	1	2	3	4
5. The following are the course objectives. Were each of the objectives discussed?				
a. The appropriate regimen of medications were matched with the cardiac dysrhythmias.	1	2	3	4
b. The preparation and administration of common cardiac crash cart medications were identified.	1	2	3	4
c. The implications in the administration of magnesium sulfate were discussed.	1	2	3	4
d. The alpha and beta adrenergic drug effects desired in treating severe asthma/anaphylactic shock were identified.	1	2	3	4
e. The dosage of the medication of choice for the comatose diabetic was identified.	1	2	3	4

OTHER SUGGESTIONS:

THANK YOU!

(Please return this evaluation form today.)

ANNEX J-1

SAMPLE NURSING RECORDS RETROSPECTIVE AUDIT FORM

UNIT_____ DEPARTMENT OF NURSING

LEGEND

+ Met criteria
- Met exception
0 Variation
Ø Justified
& Present (Informational)

DATES:_____
(Start to Complete)

DATA RETRIEVAL FORM

Responsible Recorder: _____

OBJECTIVE (TOPIC):

OBSERVATION #Chart	Criteria to be Evaluated													
1														
2.														
3.														
4.														
5.														
6.														
7.														
8.														
9.														
10.														
11.														
12.														
13.														
14.														
15.														

SAMPLE NURSING RECORDS RETROSPECTIVE AUDIT FORM

UNIT_____ DEPARTMENT OF NURSING

DATES:_____
(Start to Complete)

DATA RETRIEVAL FORM

Responsible
Recorder: _____

OBJECTIVE (TOPIC):

LEGEND

+ Met criteria
- Met exception
0 Variation
⌀ Justified
& Present (Informational)

Criteria to be Evaluated

OBSERVATION #Chart														
16.														
17.														
18.														
19.														
20.														
21.														
22.														
23.														
24.														
25.														

Total #%

Responses Found
In Compliance _____

Total #%

Respones Found
In Noncompliance _____

ANNEX J-2

COMPLETED EXAMPLE NURSING RECORDS RETROSPECTIVE AUDIT FORM
(Critical Care Area)

UNIT ICU

DEPARTMENT OF NURSING

LEGEND

- \+ Met criteria
- \- Met exception
- 0 Variation
- 0̸ Justified
- & Present (Informational)

DATES: 6/81 - 7/81 (Start to Complete)

DATA RETRIEVAL FORM

Responsible Recorder: CG Smith Marder, RN, ADN

OBJECTIVE (TOPIC): Audit Post-Op Thoracotomy (Nursing Care)

Staff: N Leve, RN AS; J Taylor, RN; L. McClay RN

OBSERVATION

Criteria to be Evaluated

#Chart	① STRIP CT q 4 hr 1st 24 hrs & PRN	② STRIP CT q 2-4° per shift thereafter until drainage stops and [illegible] confirmed		③ MD notified i.e. 2500cc [illegible]	④ CT stripping [illegible] in NN notes	⑤ [illegible]		⑥ Chest auscultated [illegible]	⑦ [illegible]	⑧ CT drainage [illegible]				
1. 219-38-2129	0	0		−	0	0		+	+	0				
2. 216-40-0558	0	0		−	0	0		+	+	0				
3. 219-05-1029	0	0		−	0	−		0	+	0				
4. 410-44-6564	+	0		−	+	−		+	+	0				
5. 214-38-2513	0	0		−	0	−		0	+	0				no flow sheet
6. 219-64-9312	0	0		−	0	0		0	+	0				no flow sheet
7. 213-20-4506	0	0		−	0	0		+	+	0				
8. 577-42-4255	0	+		−	+	0		+	+	0				
9. 215-30-6401	0	0		−	0	−		+	+	0				
10. 219-32-4016	0	0		−	0	−		+	+	0				
11. 217-26-1145	0	0		−	0	0		+	+	0				
12. 215-10-2736	0	0		−	0	−		+	+	0				NN stated CT stripped frequently
13. 11-25-80-9	0	0		−	+	0		+	+	0				
14. 2-1-81-3	0	0		−	0	0		+	+	0				
15. 219-22-6285	+	0		−	+	−		+	+	0				

COMPLETED EXAMPLE NURSING RECORDS RETROSPECTIVE AUDIT FORM
(Critical Care Area)

UNIT *ICU*

DEPARTMENT OF NURSING

LEGEND

- \+ Met criteria
- \- Met exception
- 0 Variation
- ~~0~~ Justified
- & Present (Informational)

DATES: *6/81-7-81*
(Start to Complete)

DATA RETRIEVAL FORM

Responsible Recorder: *C. J. Smith RN*

OBJECTIVE (TOPIC):

Criteria to be Evaluated

OBSERVATION #Chart	① Strip CT ē HR 1° 3° 24° & PRN	② Strip CT q 2-4° per shift thereafter	③ Initial drainage report & lung expansion confirmed	④ MD notified i.e.: 250cc/shift (in RR)	⑤ CT stripping q MS/ES/in RR	⑥ [illegible]	[illegible]	⑦ Chest auscultated q2° x ② NN or CCKS	⑧ CT drainage [illegible]	⑨ CT drainage recorded q 1-2 [illegible]				
16. 888-18-8984	+	0		0	+	0		+	+	+				
17. 579-46-7969	0	0		-	0	0		+	+	0				
18. 214-24-4614	+	+		-	+	0		0	+	0				No flow sheets
19. 218-28-0487	+	0		-	0	-		+	+	0				
20. 214-03-2582	0	0		-	0	0		0	+	0				
21. 250-36-5051	+	+		-	+	-		+	+	0				
22. 216-07-8936	0	0		-	0	-		+	+	0				
23. 348-05-9657	+	0		-	0	0		+	+	0				
24. 026-12-4217	0	0		0	+	0		+	+	0				no summary stripping but no frequency indicated
25. 100-10-4004	+	0		-	+	0		+	+	0				
Total #% Responses Found In Compliance	8/32	4/16		23/92	9/36	10/40		20/80	25/100	3/12		13/52		Avg. Compliance 51%
Total #% Respones Found In Noncompliance	17/68	21/84		2/8	16/64	15/60		5/20	0/0	22/88		12/49		Avg. Noncompliance 49%

DATA RETRIEVAL FORM - Page 2

ANALYSIS: Overall noncompliance to standards was excessive (49%). All staff record output every shift but only 12% record every 1-2 hours even initially post-op; 36% staff record chest tube stripping; only 32% staff record that chest tubes are stripped every hour in the initial 24 hours; only 16% staff record stripping of chest tube (CT) after 24 hours (although some CT are discontinued at this point). Only 8% of the staff failed to notify the MD for drainage in excess of 500cc per shift; 92% of the charts validated that staff can expect less than 500cc of drainage per shift immediately post-op (i.e., MD was called because drainage was minimal or significantly less than 500cc/shift.

It should be noted that 40% of the charts met the exception of "percussion used to assess decreased breath sounds" because breath sounds were adequate; however, 15 responses indicated that percussion was not used as an assessment tool when there were documented "decreased or poor breath sounds."

80% staff perform chest auscultation every 2 hours as evidenced by signatures on the CC/FS; 20% failed to record results of chest auscultation every 2 hours.

ACTION TO BE TAKEN:

1. Share results with staff.
2. Review standarized care plan for thoracotomy patient and finalize draft with staff consensus on time frames for post-op tasks regarding CT care, assessment, documentation.
3. Reaudit with new established standards in 6-8 months.

ANNEX J-3

SAMPLE CONCURRENT NURSING QUALITY ASSURANCE SURVEY: SPECIAL CARE UNITS

UNIT:_____ DATE:_____

A. DOCUMENTATION

ITEM NO		YES	NO	NA
1.	A list of patient's allergies is on the front of the chart	___	___	___
2.	A statement about the presence or absence of allergies was written at the time of admission.	___	___	___
3.	The patient's orientation to time, place and person is indicated.	___	___	___
4.	Respiratory rate and quality are recorded.	___	___	___
5.	The chart is assembled in the correct order as specified by hospital procedure.	___	___	___
6.	Transcribed medical orders on care plan correspond exactly as written by the physician.	___	___	___
7.	Each transcribed order is reviewed by an RN to ensure that transcription is accurate, current and complete.	___	___	___
8.	Short-term goals are described.	___	___	___
9.	There are nursing therapeutic measures which are appropriate to patient condition. (Does not apply to medical orders).	___	___	___
10.	The time and type of care related to presence of tubes (e.g., catheters, trach tubes, etc.) is stated (e.g., cleaning around tube, irrigation, etc. [Does not refer to IVs]).	___	___	___
11.	The plan for turning and positioning the patient is stated in writing.	___	___	___
CHECK LAST 24 HOURS				
12.	Nursing notes are legible.	___	___	___
13.	Charting of patient's oral fluid intake includes: a. Time fluids are given. b. Type of fluids given. c. Amount of fluids given. (All must be yes. Mark NA if patient is NPO.)	___	___	___

DOCUMENTATION (continued)

ITEM NO		YES	NO	NA
14.	IV fluids are infusing at prescribed rate.	___	___	___
15.	The patient's bowel function is recorded daily (or as prescribed).	___	___	___
16.	All treatments currently being performed are documented in the clinical record.	___	___	___
17.	Vital signs (TPR, BP) are recorded as indicated by medical or nursing orders.	___	___	___
18.	The effects of PRN medications are recorded.	___	___	___
19.	Observations related to medical treatment, medications, disease process, or possible complications are noted, e.g., changes in condition, observation to detect onset of complications.	___	___	___
20.	Records document notification of physician in event of complications or untoward effects of therapy, or change in patient's condition.	___	___	___
21.	The IV tubing is changed every 24 hours.	___	___	___
22.	The patient is assisted with ADL (eating, toilet, dressing, walking, etc.) as needed.	___	___	___
23.	Skin care is given to patient each shift (back rub, relief to pressure areas, etc.) as necessary.	___	___	___
24.	Oral hygiene is given each shift and PRN.	___	___	___

REFERENCE NUMBER REMARKS

B. PATIENT ROOM OBSERVATION

	YES	NO	NA
25. Aseptic technique is carried out as necessary in preparing or giving injections, treatments, or special procedures.	___	___	___
26. Staff wash their hands between patients.	___	___	___
27. The IV needle is correctly secured.	___	___	___
28. Electric cords on equipment used for this patient are smooth with no frayed ends or exposed wires.	___	___	___
29. The call light is within the patient's reach.	___	___	___
30. The patient is in a position for maximal lung expansions.	___	___	___
31. The urinary drainage tubing and bag are patent properly connected, and positioned for prevention of stasis.	___	___	___
32. The patient's room is clean.	___	___	___
33. All equipment in the room is in use or on standby basis, and appropriate to patient's condition.	___	___	___

REFERENCE NUMBER REMARKS

_____

_____

_____

C. PATIENT INTERVIEW

ITEM NO.

34. Measures for relief of pain or discomfort have been provided by the nursing staff.	___	___	___
35. The nursing staff introduces themselves to the patient.	___	___	___
36. The nursing staff informs the patient about activities before they are carried out on the patients.	___	___	___

REFERENCE NUMBER REMARKS

_____

_____

_____

D. NURSE INTERVIEW

	YES	NO	NA
37. Precautions are taken by nursing staff to protect patients from known infections or other infected patients.	___	___	___
38. The location of poison control number is known.	___	___	___
39. The emergency cart has been checked for adequacy of supplies.	___	___	___
40. Tasks are delegated according to both patient needs and personnel skill levels.	___	___	___
41. Patient conferences are conducted to plan and coordinate specific patient's care.			
42. Physicians' orders are transcribed within one hour after they are written.	___	___	___

REFERENCE NUMBER REMARKS

_____

_____

_____

E. PHYSICIAN INTERVIEW

ITEM NO.

43. The physician is satisfied with the nursing care provided.	___	___	___

REFERENCE NUMBER REMARKS

_____

_____

_____

F. UNIT OBSERVATION

44. Needles and syringes are disposed of in impervious containers. ___ ___ ___

45. The defibrillator is plugged in and prepared for use. ___ ___ ___

46. A registered nurse is in charge and present on the unit this shift. ___ ___ ___

47. Refrigerated medications are separated from food storage. ___ ___ ___

REFERENCE NUMBER REMARKS

_____

_____

_____

TOTAL ___ ___ ___

___ ___ ___

OBSERVER _____

TIME _____ _____

ANNEX N

OFFICER EVALUATION REPORT SUPPORT FORM

For use of this form, see AR 623-105; the proponent agency is DCSPER.

Read Privacy Act Statement on Reverse before Completing this form

PART I – RATED OFFICER IDENTIFICATION

NAME OF RATED OFFICER (Last, First, MI)	GRADE	ORGANIZATION
DOE, JANE A.	2LT	USA MEDDAC

PART II – RATING CHAIN – YOUR RATING CHAIN FOR THE EVALUATION PERIOD IS:

	NAME	GRADE	POSITION
RATER	X.R. CISE	CPT	Head Nurse
INTERMEDIATE RATER			
SENIOR RATER	F. NIGHTENGALE	LTC	Section Supervisor

PART III – VERIFICATION OF INITIAL FACE-TO-FACE DISCUSSION

AN INITIAL FACE-TO-FACE DISCUSSION OF DUTIES, RESPONSIBILITIES, AND PERFORMANCE OBJECTIVES FOR THE CURRENT RATING PERIOD TOOK PLACE ON _____

RATED OFFICER'S INITIALS _____ _____ RATER'S INITIALS _____

PART IV – RATED OFFICER *(Complete a, b, and c below for this rating period)*

a. STATE YOUR SIGNIFICANT DUTIES AND RESPONSIBILITIES

DUTY TITLE IS _____, THE POSITION CODE IS _____

Clinical staff nurse, general medicine ward with average census of thirty-six patients. Supervises 1-2 paraprofessionals.

b. INDICATE YOUR MAJOR PERFORMANCE OBJECTIVES

1. Obtain 5 CEU's within next three months.
2. Provide inservice for paraprofessionals at least quarterly.
3. Complete physical assessment workshop at next offering.
4. Join National League of Nurses.
5. Attend emergency drug seminar offered with next CPR recertification -- Sep 84.
6. Develop standardized care plan for decubitus ulcer care and care of patient status, post cardiac catheterization with 2LT Mary Smith.
7. Work with CPT Johnson on staff development days to prepare for change nurse responsibilities.

c. LIST YOUR SIGNIFICANT CONTRIBUTIONS

SIGNATURE AND DATE

PART V – RATER AND/OR INTERMEDIATE RATER *(Review and comment on Part IVa, b, and c above. Insure remarks are consistent with your performance and potential evaluation on DA Form 67–8.)*

a. RATER COMMENTS *(Optional)*

SIGNATURE AND DATE *(Mandatory)*

b. INTERMEDIATE RATER COMMENTS *(Optional)*

SIGNATURE AND DATE *(Mandatory)*

DATA REQUIRED BY THE PRIVACY ACT OF 1974 *(5 U.S.C. 552a)*

1. **AUTHORITY:** Sec 301 Title 5 USC; Sec 3012 Title 10 USC.

2. **PURPOSE:** DA Form 67–8, Officer Evaluation Report, serves as the primary source of information for officer personnel management decisions. DA Form 67–8–1, Officer Evaluation Support Form, serves as a guide for the rated officer's performance, development of the rated officer, enhances the accomplishment of the organization mission, and provides additional performance information to the rating chain.

3. **ROUTINE USE:** DA Form 67–8 will be maintained in the rated officer's official military Personnel File (OMPF) and Career Management Individual File (CMIF). A copy will be provided to the rated officer either directly or sent to the forwarding address shown in Part I, DA Form 67–8. DA Form 67–8–1 is for organizational use only and will be returned to the rated officer after review by the rating chain.

4. **DISCLOSURE:** Disclosure of the rated officer's SSN (Part I, DA Form 67–8) is voluntary. However, failure to verify the SSN may result in a delayed or erroneous processing of the officer's OER. Disclosure of the information in Part IV, DA Form 67–8–1 is voluntary. However, failure to provide the information requested will result in an evaluation of the rated officer without the benefits of that officer's comments. Should the rated officer use the Privacy Act as a basis not to provide the information requested in Part IV, the Support Form will contain the rated officer's statement to that effect and be forwarded through the rating chain in accordance with AR 623–105.

ANNEX L

JOB PERFORMANCE PLANNING WORKSHEET
For use of this form, see AR 690-400, Chapter 430; the proponent agency is DCSPER.

PAGE NO. 1 | NO OF PAGES 3

PART I - ADMINISTRATIVE DATA

1. POSITION TITLE, PAY PLAN, SERIES, GRADE, AND JOB DESCRIPTION NO.
Clinical Nurse, GS0610, GS09, 58-79 (ICU/CCU)

2. NAME AND LOCATION OF EMPLOYING ACTIVITY
Dept of Nursing, USA MEDDAC

3. NAME (Last, First, MI) AND SSN

4. RATING PERIOD
FROM: THRU:

PART II - PERFORMANCE REQUIREMENTS

a. MAJOR JOB ELEMENTS	b. CRITICAL ELEMENT	c. SUPPORTING TASKS	d. PERFORMANCE STANDARDS
Planning and coordination of patient care	YES	1. Collects data.	1a. Completes nursing admission note on SF 510 and/or 3888-1 on admission and/or prior to termination of the shift on which the patient was admitted. No deviation from standard. b. Completes nursing data base (using interview, observation, nursing assessment, and/or record review) within 24 hours of patient admission to nursing unit. No exception to standard.
		2. Formulates nursing diagnosis.	2a. Records nursing diagnosis; states as nursing problems on DA Form 3888-1. No deviation from standard. b. Formulates nursing diagnosis and support with nursing assessment findings that are recorded on SF 510 and or DA Form 3888 and 3888-1. No deviation from standard.
Planning and implementation	YES	1. Sets nursing goals based upon nursing diagnosis.	1a. Formulates long and short term goals derived from nursing diagnosis and reflects on DA Form 3888 and 3888-1. No more than 2 counseling sessions for deficiency during rating period. b. Formulates a minimum of one (1) nursing order for each patient goal concurrent with identification of the goal. No more than 2 counseling sessions for deficiency during rating period. c. Reviews and confirms or updates nursing diagnosis, goals and orders at no less than every eight (8) hours per unit SOP. No deviation from standard.
		2. Discharge planning	2a. Initiates DA 4700 O/P 129 (discharge planning form) upon admission. b. Documents all referrals to other health care providers on discharge planning form. No deviation from standard.

c. DA FORM 4950-1 (JOB PERFORMANCE PLANNING WORKSHEET - PART II CONTINUATION) ATTACHED | | YES | | NO

DA FORM 4950

PART III - CHANGES TO PERFORMANCE REQUIREMENTS

7. MAJOR JOB ELEMENTS *(including critical elements and performance standards)* CHANGED DURING RATING PERIOD

8. RATIONALE FOR CHANGES MADE

PART IV - AUTHENTICATION

9. SIGNATURES	NAME, GRADE *(if military)*, TITLE, & ORGANIZATION	DATE
a RATING SUPERVISOR		
b REVIEWER		
c EMPLOYEE[1]		

[1] *Employee's signature indicates that a copy of the worksheet has been provided and that the major elements, critical elements, and performance standards have been discussed with him or her. It does not necessarily indicate agreement.*

JOB PERFORMANCE PLANNING WORKSHEET - PART II CONTINUATION

For use of this form, see AR 690-400, Chapter 430; the proponent agency is DCSPER.

PAGE NO 2 | NO OF PAGES 3

PART I - ADMINISTRATIVE DATA

2 POSITION TITLE, PAY PLAN, SERIES, GRADE, AND JOB DESCRIPTION NO

Clinical Nurse, GS0610, GS09, 58-79 (ICU/CCU)

3 NAME (Last, First, MI) AND SSN

4 RATING PERIOD FROM: THRU:

PART II - PERFORMANCE REQUIREMENTS (Continued)

a. MAJOR JOB ELEMENTS	CRITICAL ELEMENT	c. SUPPORTING TASKS	d. PERFORMANCE STANDARDS
Implementation and evaluation.	YES	1. Implementation of nursing and medical orders.	1a. Changes IV tubing no less than every 48 hours labels tubing with date and time of change and initials the label per SOP. Requires counseling for non-compliance no more than 2 times per rating period. b. Changes IV site dressing no less than every 2 hours. Labels outer dressing with date and time of change and initials per SOP. Requires counseling for non-compliance no more than 2 times per rating period. c. Records the reason for implementation, the action taken and the results of action for all PRN orders. Requires counseling for non-compliance no more than 2 times per rating period. c. Records the reason for implementation, the action taken and the results of action for all PRN orders. Requires counseling for non-compliance no more than 2 times per rating period.
		2. Administers prescribed medications (oral, sub-q, intra-muscular, IV).	2a. Records changes in dosage of titration drugs (i.e., Dopamine, Lidocaine, etc.) and patient's response to these changes on SF 510. No deviation from standard accepted. b. In accordance with accepted standards of practice. No deviation acceptable. c. Transcribes, without error, doctor's orders on DA Form 4677 and 4678. No deviation from standard accepted.
		3. CPR certification.	3a. Achieve CPR certification and renew certification annually. No deviation from standard accepted. (Forms review in NETS)
		4. Sets up, operates and monitors specialized equipment.	4a. Within 90 days after assignment to the nursing unit, demonstrates and/or describes the proper operating procedure, describes when to utilize and

DA FORM APR 81 4968-1

PART II - PERFORMANCE REQUIREMENTS (Continued)			
b. MAJOR JOB ELEMENTS	c. CRITICAL ELEMENT	e. SUPPORTING TASKS	d. PERFORMANCE STANDARDS
			lists appropriate actions in malfunction of the following equipment, per SOP: (1) EKG machine (2) EKG monitor (3) Telemetry (4) Arterial lines (5) Swan-Ganz lines (6) Transvenous pacemaker insertion (7) Ventilator (8) Dinamapp (9) Suction equipment Must demonstrate proficiency without deviation following orientation. b. Within 90 days after assignment to the nursing unit, demonstrates and/or describes the proper procedure and rationale for cardioversion and defibrilation per SOP. Must demonstrate proficienc without deviation following orientation. c. Within 90 days after assignment to the nursing unit, demonstrates and/or describes the correct procedure for: (1) Collection of ABG's: (a) with arterial line (b) without arterial line (2) Correct procedure for obtaining arterial reading and Swan-Ganz readings. (3) Correct procedure for obtaining cardiac output readings. No deviation from standard following orientation.
Patient teaching	YES	1. Patient/significant other teaching.	1a. Documents performance of assigned and incidental teaching, includes summary of content, teaching method and patient/significant other response on SF 510. No more than 2 valid complains of, or deficiences during rating period. b. Initiates cardiac rehab protocol when medically ordered. Initiates and continues documentation per protocol on SF 510. No deviation from standard.
Unit administration	YES	1. Completes nursing related records and reports.	1a. Completes nursing unit 24 hours report IAW DONAP, completes unit manpower report. Documentation of required and significant unit occurrences is present. Requires counseling no mor than 2 times for non-compliance.

JOB PERFORMANCE PLANNING WORKSHEET - PART II CONTINUATION

For use of this form, see AR 690-400, Chapter 430; the proponent agency is DCSPER

PAGE NO 3 | NO OF PAGES 3

PART I ADMINISTRATIVE DATA

1. NAME (Last, First, MI), GRADE AND JOB DESCRIPTION NO

Clinical Nurse, 65D10, 6509, 58-29 (TCD/CCD)

4. RATING PERIOD

FROM THRU

PART II PERFORMANCE REQUIREMENTS (Continued)

a. [illegible]	b. [illegible]	c. SUPPORTING TASKS	d. PERFORMANCE STANDARDS
		2. Assigns patient care and unit administration duties.	2a. Assigns patient care and unit maintenance task according to patient care requirements and employee skill/experience levels. Requires counseling for non-compliance not more than two times per rating period. b. Reviews, verifies and augments patient care assignments prepared by employee to assure adequate detail for accomplishment of care per SOP. Requires counseling for non-compliance no more than two times per rating period. c. Confirms accomplishment of patient care and unit administration tasks by others during change of shift report and nursing rounds, per SOP. No deviation from standard. d. Does not discuss patient's condition/situation within hearing distance of other patient or relatives. No deviation from standard.
Professional development.		2. Education, training and administrative programs.	1. Attends mandatory education, training and administrative programs on duty time as assigned by immediate supervisor. No deviation from standard. 2. Maintains current RN license according to individual state requirement. No deviation from standard. 3. Participates in defining areas of own responsibility during counseling sessions with supervisor. Input will be reflected in quarterly counseling memorandum. 4. Responsibile for providing one (1) educational inservice program per year to co-workers on duty time. (Form review NETS and/or ward record). 5. Participates in a minimum of 50% of staff meetings on duty and initials minutes of meeting that were not attended within two weeks of posting. No deviation from standard. (Review of attendance

DA FORM APR 81 4960-1

PART II - PERFORMANCE REQUIREMENTS (Continued)

5. a. MAJOR JOB ELEMENTS	b. CRITICAL ELEMENT	c. SUPPORTING TASKS	d. PERFORMANCE STANDARDS
			and initial roster posted with minutes.)

ANNEX M-1

PERFORMANCE STANDARDS: CLINICAL HEAD NURSE

Definition:

A professional nursing position to provide unit administration, nursing care management, and supervisory control of assigned nursing personnel and their nursing activities. This RN insures expert nursing care to patients on his/her assigned unit and provides leadership of assigned personnel in the activities, organization, understanding, and effectiveness of assignments made in order to meet the nursing needs of the patient group.

PERFORMANCE STANDARDS: CLINICAL HEAD NURSE

A. MAJOR JOB ELEMENTS	B. SUPPORTING TASKS	C. PERFORMANCE STANDARDS
1. Administrator/Manager	a. Schedules staff, professional and non-professionals for the purpose of coverage 7 days a week 24 hours a day. The coverage provided will be based on patient's condition, number of personnel assigned, DON Admin Guide, and Labor Contract local AFCR.	a. Maintains an equitable schedule for all staff using established guidelines and patient requirements.
	b. If nursing shortages exist, the IN will attempt to correct these deficiencies or will contact C, Nursing Section.	b. Provides coverage 7 days a week 24 hours a day. When deficiencies/shortages exist and IN cannot cover, the Head Nurse will contact Chief, Nursing Section as soon as possible.
	c. Posts time schedules 2 weeks in advance.	c. Schedules will be posted two weeks in advance.
	d. Keeps statistical data for preparation of manpower report.	d. Records will be maintained for manpower survey.
	e. Maintains records and reports.	e. Responsible for all records and reports maintained and initiated on the unit according to AR 40-407, DON Admin Guide and other DON policies and unit SOP's. All records and reports will be maintained correctly, in a timely manner, and according to designated suspense date.

PERFORMANCE STANDARDS: CLINICAL HEAD NURSE

A. MAJOR JOB ELEMENTS	B. SUPPORTING TASKS	C. PERFORMANCE STANDARDS
1. Administrator/Manager (Continued)	f. Works in harmony with MC Officers and Chief, Nursing Section in establishing and implementing special unit policies. Works within the framework, philosophy, and goals of the Dept of Nursing. Establishes standards of nursing care based on written established standards of the nursing profession, the ANC, the JCAM, and those of the C, Dept of Nursing	f. Responsible to the Chief, Nursing Section, Chief, Dept of Nursing and M Officers for the standard of nursing care rendered, and the implementation nursing service policies.
	g. Investigates errors, omissions, accidents, complaints and reports as required.	g. Aids the Dept of Nursing in providing for quality patient care through risk management.
	h. Skillfully communicates and works in a positive manner with peers to coordinate care for patients and to establish mutual goals.	h. Utilizes interpersonal relationship skills when dealing with all personnel and patients.
2. Personnel Management; Coordinator	a. Plans and coordinates nursing care through the use of the nursing process and the AMEDD Standards of Nursing Practice (SONP). Nursing forms will be initiated according to DON SOP's and the AMEDD SONP. The nursing plan of care will be coordinated with the patient's medical plan of care and will be developed from the nursing history and assessment forms.	a. Responsible for the organization and quality of all nursing care performed on the unit and for the coordination of all nursing activities within the unit through documented assessment, planning and directing care to meet the needs of the patient.
	b. Organizes, coordinates, and delegates nursing care services.	b. Establishes priorities of patient care, organizes patient care, coordinates staff activities and delegates patient care assignments.
	c. Provides written patient care assignments to each staff member. These assignments to be coordinated with the wardmaster.	c. Writes patient care assignments for each staff member.

PERFORMANCE STANDARDS: CLINICAL HEAD NURSE

A. MAJOR JOB ELEMENTS	B. SUPPORTING TASKS	C. PERFORMANCE STANDARDS
2. Personnel Management: Coordinator (Continued)	d. Insures that patient care assignments are commensurate with qualifications of the providers of care and the needs of the patient.	d. Delagates tasks and work assignments according to skill level, job description, written standards of performance for each position, and the needs of the patient.
	e. Supervises all staff members in the performance of assigned duties. Counsels all staff members every 90 days in the performance of their duties. Documents these sessions. Plans, conducts and documents monthly staff meetings.	e. Conducts and participates in patient care conferences. Conducts, participates, and documents staff meetings and 90 day counselling sessions.
	f. Maintains interim documentation when performance of duty falls below that of the written standards.	f. This counselling and documentation will be performed by the head nurse, signed by the head nurse and the employee.
	g. Identifies the needs of assigned personnel and coordinates with the wardmaster, Nursing Section Chief, and/or C, NESD to meet these needs.	g. The Head Nurse must be able to identify those needs which may interfere with the individual's performance of duty to meet these needs through counselling, training, disciplinary action, awards, etc.
	h. Conducts and schedules ward inservices.	h. Schedules and conducts ward inservices which will enhance the skill level of assigned staff.
3. Nursing Process	a. Routine admission care; collects data about the health status of the patient. Documents nursing assessment and history of each patient. Establishes priority of information according to physical condition of the patient. Communicates the data base to appropriate persons. Documents data base.	a. Completes initial assessment and establishes data base within 24 hours of admission. Data base will include a nursing history, a nursing assessment and a review of systems (biophysical status) as appropriate for planning care. Data is collected in a systematic and continuous manner. Information is documented in the record (DA Form 3888 and 3888-1). RN is responsible for the nursing assessment and plan of care.

PERFORMANCE STANDARDS: CLINICAL HEAD NURSE

A. MAJOR JOB ELEMENTS	B. SUPPORTING TASKS	C. PERFORMANCE STANDARDS
3. Nursing Process (Continued)		a. (Continued) If no nursing intervention is needed at admission as determined by the assessing nurse, a review date will be established and a statement to the effect recorded in the nursing record. If a patient is transferred, the receiving RN will review the patient's records and document the review in the nurses' notes. Frequently changing and/or highly indicative data will be recorded on a flowsheet and maintained in the medical record.
	b. Formulates and documents the nursing care plan (DA Form 3888-1)	b. Makes nursing diagnosis(es) related to the patient's health problems. Nursing diagnoses will be documented on DA Form 3888-1 as problems. The nursing diagnoses will be prioritized, reviewed and revised. They will be consistent with current scientific knowledge and will include deviations determined by comparing the identified data to established norms, and/or patient's previous condition. Nursing care plan is indivdualized for each patient and based on the data base and nursing diagnoses.
	c. Formulates nursing goals/objectives.	c. Formulates nursing goals which will be stated in terms of patient's outcome and are directed to meeting identified needs. These goals may address high risk complications, management of treatments and interventions; are mutually formulated by the patient and/or significant other and health care providers. The goals should be achievable within an identified period of time and are attainable through available resources. The goals will be aligned with DON Patient Outcome Standards. The nursing care plan will be designed to achieve the nursing goals and will be based on current scientific knowledge.

PERFORMANCE STANDARDS: CLINICAL HEAD NURSE

A. MAJOR JOB ELEMENTS	B. SUPPORTING TASKS	C. PERFORMANCE STANDARDS
3. Nursing Process (Continued)	d. Prescribes nursing actions and orders.	d. Nursing actions and orders will be documented on DA Form 4677 and are written to implement the nursing plan of care and assist the patient to maximize health capabilities.
	e. Implements the nursing care plan.	e. The effectiveness of the nursing care plan will be documented in the nursing notes (SF 510). The patient's progress or lack of progress toward goal achievement will be assessed and documented.
	f. Revises the nursing care plan.	f. If there is lack of progress as determined by the patient, significant other and the nurse, reassessment will be done. New priorities will be established along with the development of new goals and a new plan of patient care.
	g. Prepares patients for surgical and diagnostic procedures; closely observes patients making nursing and physical assessments of post-op and SI patients for: adverse conditions, reactions, untoward symptoms. Records findings. Assesses vital signs, dressings, drainage tubes for excessive bleeding or drainage. Records findings and actions.	g. Prepares patient for surgical and diagnostic procedures IAW established nursing policies and to MD's orders. Assessments are made in graduated increments of 15 minutes to every 4 hours, or as MD's orders. Records assessments and actions taken using precise descriptive language (color; consistency; volume; measurements taken; location, duration, and frequency in cases of nausea, diarrhea or pain).
	h. Initiates and administers prescribed medications (oral, IM, SC, topical), oxygen, IV fluids, blood transfusions and blood products per MD's Orders.	h. Administers all prescribed medications and blood products with 100% accuracy. Reports all errors to MD and nursing supervisor ASAP.

PERFORMANCE STANDARDS: CLINICAL HEAD NURSE

A. MAJOR JOB ELEMENTS	B. SUPPORTING TASKS	C. PERFORMANCE STANDARDS
3. Nursing Process (Continued)	i. Documents therapeutic and adverse drug or blood reactions including side effects and nursing actions taken.	i. Documents drugs and blood product reactions; documents the observed effect of all prn medications.
	j. Teaches patient; documents patient's understanding of prescribed medications including name, dose, time taken, side effects, etc., before discharge.	j. Must document all patient teaching in terms of patient understanding (See Critical Element 5 Teaching).
	k. Assists with and renders direct nursing care to patients undergoing or having undergone, special procedures, such as intubation, catheter insertion, lumbar punctures, chest tube insertion, blood sampling, etc.	k. Utilizes or maintains aseptic technique. Seeks help as needed. Observes and documents any adverse reactions. Advises proper personnel of any adverse reaction.
4. Maintains records	a. Maintains clinical records IAW to AR 40-407.	a. Source document for this Element is AR 40-407. All nursing records will be maintained IAW the AR.
	b. Enters nursing data base and assessment on DA Form 3888 and initiates nursing care plan DA Form 3888-1.	b. Initial assessment and care plan will be made within 24 hours. More indepth assessment and care plan will be completed within 48 hours.
	c. DA Form 4677 will be maintained for each patient.	c. Nursing orders will be ordered on this form and must be signed by RN initiating the order.
	d. Maintains nursing notes (SF 510).	d. Content of nursing notes is dictated in para AR 40-407, para 2-B.
	1. Admission notes will be made on each patient and will include data, time, manner of admission, reported known allergies and a brief, clear description of symptoms and pertinent observation.	

PERFORMANCE STANDARDS: CLINICAL HEAD NURSE

A. MAJOR JOB ELEMENTS	B. SUPPORTING TASKS	C. PERFORMANCE STANDARDS
4. Maintains Records (Continued)	e. Patient Discharge Plan (DA Form 4700) 1. Nurse will enter date, time, manner of discharge and concise summary of discharge plan. The nurse will document health teaching appropriate to disease, drugs, and desired patient outcome.	e. Content and instructions to complete Discharge Planning Form (DA Form 4700) is dictated AR 40-407, para 2-9.
	f. Maintains all other records IAW AR-40-407.	f. Will maintain all records IAW AR 40-407.
5. Teaching	a. Plans and participates in patient teaching experiences based on needs as identified in the care plan and the local Patient Outcome Standards.	a. All teaching and patient's/SO understanding of instruction, will be documented.
	b. Plans programs which are based on current scientific knowledge and available patient teaching booklets.	b. Return demonstrations will be documented in the nursing notes.
	c. Plans programs of instruction to staff members.	c. RNs are expected to plan and participate in informal ward inservice programs and in continuing education programs given by the Nursing Education & Staff Development section.
6. EEO	a. Assists the Dept of Nursing in the interviewing of prospective employees.	a. Interviews all prospective employees when assigned by the Dept of Nursing.
	b. Treats all employees equally without regard to race, creed, religion and/or sex.	b. Actively supports and practices local EEO policy.

PERFORMANCE STANDARDS: CLINICAL HEAD NURSE

A. MAJOR JOB ELEMENTS	B. SUPPORTING TASKS	C. PERFORMANCE STANDARDS
7. Patient Advocate	a. Provides for patient's safety, privacy, and participation in care. Supports and preserves the patient's right for independence of expression, decision, and action and concern for personal dignity and human relationships.	a. All patients will be treated with respect, courtesy and tact. Whenever possible, individual privacy will be provided to the patients. All special procedures and studies will be explained to the patient. Insures that: 1) Written voluntary consent is granted by the patient prior to procedures; 2) Insures that patient's personal area and possessions are respected and protected from unwarranted intrusion; 3) confidentiality of the medical record is maintained. Discreetly conducts all discussions and consultations involving the patient. Insure individuals not directly involved in the patient's care will not be present without the patient's consent. Recognizes and respects the right of the patient to refuse treatment to the extent permitted by law. Insures reasonable safety insofar as the hospital practices and environment affect the patient. Honors the patient's designation of significant other.
8. Professional Role	a. Each RN will be annually certified in CPR, basic life support and definitive drug therapy.	a. Each nurse will be certified annually through training CPR. Knows the location of CPR cart, oxygen equipment and knows operation of equipment to include defibrillation and EKG machine. Must know definitive drug therapy used in basic life support.

PERFORMANCE STANDARDS: CLINICAL HEAD NURSE

A. MAJOR JOB ELEMENTS	B. SUPPORTING TASKS	C. PERFORMANCE STANDARDS
B. Professional Role (Continued)	b. Assesses own performance in accordance with established standards of practice and assists with the development of new standards.	b. Each RN will insure that his/her practice is in accordance with written standerds.
	c. Participates in quality assurance programs. Obtains continuing learning experiences. Orients new staff members. Determines, plans, and meets unit goals.	c. Each RN will participate in quality assurance programs.
	d. Belongs to at least one professional organization or attends courses, inservices or reads current nursing journals and texts or plans and conducts inservices and participates in Dept of Nursing continuing education programs. Participates in effecting needed changes within own area of practice. Assists in improving nursing practice.	d. Each professional nurse takes responsibility for his/her own professional growth and holds the philosophy that one should continue to develop professionally. Assumes responsibility for own continuing education. Maintains ethical code consistent with the ANA's "Code for Nurses."

ANNEX M-2

PERFORMANCE STANDARDS: CLINICAL STAFF NURSE

Definition:

Clinical staff nurse is a professional nursing position. This RN will insure that expert nursing care is provided to assigned group of patients on the unit. This RN is responsible to the Clinical Head Nurse for the quality of nursing care rendered by him/her and the activity of the assigned personnel. Incumbent holds current, valid licensure.

PERFORMANCE STANDARDS: CLINICAL STAFF NURSE

A. BASIC JOB ELEMENTS 1. Nursing Process	B. SUPPORTING TASKS	C. PERFORMANCE STANDARDS
	a. Routine admission care; collects data about the health status of the patient. Documents nursing assessment and history of each patient. Established priority of information according to physical condition of the patient. Communicates the data base to appropriate persons. Documents data base.	a. Completes initial assessment and establishes data base within 24 hours of admission. Data base will include a nursing history, a nursing assessment and a review of systems (biophysical status) as appropriate for planning care. Data is collected in a systematic and continuous manner. Information is documented on (DA Form 3888 and 3888-1). RN is responsible for the nursing assessment and plan of care. If no nursing intervention is needed at admission, as determined by the assessing nurse, a review date will be established and a statement to the effect recorded in the nursing record. If a patient is transferred, the receiving RN will review the patient's records and document the review in the nurses' notes. Frequently changing and/or highly indicative data will be recorded on a flow sheet and maintained in the medical record.
	b. Formulates and documents the nursing care plan (DA form 3888-1).	b. Makes nursing diagnosis(es) related to the patient's health problems, Nursing diagnoses will be documented on DA Form 3888-1 as problems. The nursing diagnoses will be prioritized, reviewed and revised. They will be consistent with current scientific knowledge and will include deviations determined by comparing the identified data to previous condition. Nursing care plan is individuali for each patient and based on the data base and nursing diagnoses.
	c. Formulates nursing goals/objectives.	c. Formulates nursing goals which will be stated in terms of patient's outcomes and are directed to meeting identified needs.

PERFORMANCE STANDARDS: CLINICAL STAFF NURSE

A. MAJOR JOB ELEMENTS	B. SUPPORTING TASKS	C. PERFORMANCE STANDARDS
1. Nursing Process (Continued)		c. (Continued) These goals may address high risk complications, management of treatments and interventions; are mutually formulated by the patient and/or significant other and health care providers. The goals should be achievable within an identified period of time and are attainable through available resources. The goals will be aligned with stated DON Patient Outcome Standards. The nursing care plan will be designed to achieve the nursing goals and will be based on current scientific knowledge.
	d. Prescribes Nursing actions and orders.	d. Nursing actions and orders will be documented on DA Form 4677 and are written to implement the nursing plan of care and to assist the patient to maximize health capabilities.
	e. Implements the nursing care plan.	e. The effectiveness of the nursing care plan will be documented in the nursing notes (SF 510). The patient's progress or lack of progress toward goal achievement will also be assessed and documented.
	f. Revises the nursing care plans.	f. If there is lack of progress as determined by the patient, significant other and the nurse, reassessment will be done. New priorities will be established along with the development of new goals and a new plan of patient care.
2. Nursing Care Activities	a. Prepares patients for surgical and diagnostic procedures. Closely observes patients making nursing and physical assessments of post-op and SI patients for: adverse conditions,	a. Prepares patients for surgical and diagnostic procedures IAW established nursing policies and to MD's orders. Assessments are to be made in graduated increments of

PERFORMANCE STANDARDS: CLINICAL STAFF NURSE

A. MAJOR JOB ELEMENTS	B. SUPPORTING TASKS	C. PERFORMANCE STANDARDS
2. Nursing Care Activities (Continued	a. (Continued) reactions, untoward symptoms: Records findings. Assesses vital signs, dressings, drainage tubes for excess i.e., bleeding, or drainage. Records findings and actions.	a. (Continued) 15 minutes to every 4 hours, or as per MD's orders. Records assessments and actions taken using precise descriptive language (color; consistency; volume; measurements taken; location, duration and frequency in cases of nausea, diarrhea or pain.
	b. Initiates and administers prescribed medications (oral, I.M., S.C. topical), oxygen, IV fluids, blood transfusions and blood products per MD's orders.	b. Administers all prescribed medications and blood products with 100% accuracy. Reports all errors to MD and nursing supervisor ASAP.
	c. Documents therapeutic and adverse drug or blood reactions including side effects and nursing actions taken.	c. Documents drug and blood product reactions; documents the observed effect of all prn medications.
	d. Teaches patient; documents patient's understanding of prescribed medications including name, dose, time taken, side effects, etc. before discharge.	d. Must document all patient teaching in terms of patient understanding (See Standard 4 Teaching).
	e. Assists with and renders direct nursing care of patients undergoing, or having undergone, special procedures such as intubation, catheter insertion, lumbar punctures, blood sampling, etc.	e. Utilizes or maintains aseptic technique. Seeks help as needed. Observes and documents any adverse reactions. Advises proper personnel of any adverse reaction.

PERFORMANCE STANDARDS: CLINICAL STAFF NURSE

A. MAJOR JOB ELEMENTS	B. SUPPORTING TASKS	C. PERFORMANCE STANDARDS
3. Maintains Records	a. Maintains clinical records IAW AR 40-407.	a. Source document for this standard is AR 40-407. All nursing records will be maintained IAW the AR.
	b. Enters nursing data base and assessment on DA Form 3888 and initiates nursing care plan DA Form 3888-1.	b. Initial assessment and care plans will be made within 24 hours. More indepth assessment and care plan will be completed within 48 hours.
	c. DA Form 4677 will be maintained for each patient.	c. Nursing orders will be ordered on this form and must be signed by RN initiating the order.
	d. Maintains Nursing Notes (SF 510).	d. Content of nursing notes is dictated in AR 40-407, para 2-8.
	(1) Admission notes will be made on each patient and will include date, time, manner of admission, reported known allergies, and a brief clear description of symptoms and pertinent observations.	
	e. Patient Discharge Plan (DA Form 4700)	e. Content and instructions to complete Discharge Planning form (DA Form 4700) dictated in AR 40-407, para 2-9.
	(1) Nurse will enter date, time, manner of discharge and concise summary of discharge plan. The nurse will document health teaching appropriate to disease, drugs, and desired patient outcomes.	
	f. Maintains all other records according to AR 40-407.	f. Will maintain all records IAW AR 40-407.

PERFORMANCE STANDARDS: CLINICAL STAFF NURSE

A. MAJOR JOB ELEMENTS	B. SUPPORTING TASKS	C. PERFORMANCE STANDARDS
4. Teaching	a. Plans and participates in patient teaching experiences based on needs as identified in the care plan and the local Patient Outcome Standards.	a. All teaching and patient's/SO understanding will be documented.
	b. Plans programs which are based on current scientific knowledge and available patient teaching booklets.	b. Return demonstrations will be documented in the nursing notes.
	c. Evaluates programs of instruction by return demonstration by the patient.	c. RNs are expected to plan and participate in informal ward inservice programs and in continuing education program given by the Nursing Education & Staff Development Service.
	d. Plans programs of teaching and instructions to peers and assigned paraprofessional staff.	d. Will conduct and document all teaching.
5. Personnel Management	a. Organizes, coordinates and delegates nursing care services.	a. The RN will demonstrate competency in establishing priorities of care, organizing patient care, coordinating staff activities and delegating patient care assignments.
	b. Provides written patient care assignments to each staff member.	b. Delegates tasks according to: 1) staff member's skill level, job description and written standards of the position; and 2) the needs of the patient.
	c. Insures that patient care assignments are commensurate with qualifications of the provider of care and the needs of the patient.	c. Writes patient care assignments for each staff member. Refers staff members to DA Form 4677 for nursing & MD orders.
	d. Supervises paraprofessional staff in the performance of assigned duties.	d. Conducts and participates in patient care conferences, staff meetings, and, as necessary, periodic counseling of staff.

PERFORMANCE STANDARDS: CLINICAL STAFF NURSE

A. MAJOR JOB ELEMENTS	B. SUPPORTING TASKS	C. PERFORMANCE STANDARDS
b. Professional Behavior a. Patient Advocate	a. Provides for patient's safety, privacy, and participation in care. Supports and preserves the patient's right for independence of expression, decision, and action and concern for personal dignity and human relationship.	a. All patients will be treated with respect, courtesy, and tact. Whenever possible, audiovisual privacy will be provided to the patient. All special procedures and studies will be explained to the patient. Insures that: 1) written voluntary consent is granted by the patient prior to procedures; 2) patient's personal area and possessions are respected and protected from unwarranted intrustion; 3) confidentiality of the medical record is maintained. Discreetly conducts all discussions and consultations involving the patient. Insures individuals not directly involved in the patient's care will not be present without the patient's consent. Recognizes and respects the right of the patient to refuse treatment to the extent permitted by law. Insures reasonable safety insofar as the hospital practices and environment affect the patient. Honors the patient's designation of significant other.
b. Basic Life Support Certification	a. Each RN will be annually certified in CPR, basic life support and definitive drug therapy.	a. Each RN will be certified annually through training in CPR. Knows the location of CPR cart, oxygen equipment and knows operation of equipment to include defibrillator and EKG machine. Must know definitive drug therapy used in basic life support.
c. Leadership role	a. Serves as the charge nurse.	a. Each RN assigned to the DON is able to function in the charge nurse role.
	b. Assesses own performance in accordance with established standards of practice and assists with the development of new standards	a. Each RN will participate in developing standards of practice for his/her own position and will insure that his/her practice is in accordance with these standards.

PERFORMANCE STANDARDS - CLINICAL STAFF NURSE

A. MAJOR JOB ELEMENTS	B. SUPPORTING TASKS	C. PERFORMANCE STANDARDS
6. Professional Behavior (continued)	c. Participates in quality assurance programs. Obtains continuing learning experiences.	c. Each RN will participate in quality assurance programs.
	d. Determines, plans and meets unit goals.	d. Will assist Head Nurse in determining, planning, and meeting unit goals.
	e. Belongs to at least one professional organization or attends courses, inservices or reads current nursing journals and texts or plans and conducts inservice and participates in Dept of Nursing continuing education programs.	e. Each professional nurse will take responsibility for his/her own professional growth and holds the philosophy that one should continue to develop professionally.
	f. Participates in effecting needed changes within own area of practice.	f. Assumes responsibility for own continuing education.
	g. Assists in improving nursing practice.	g. Maintains ethical code consistent with the ANA's "Code for Nurses."
	h. Maintains correct personal appearance and uniform.	h. Will maintain personal appearance and uniform IAW US Army Regulations and local policies.

ANNEX M-3

PERFORMANCE STANDARDS: 91C/LICENSED PRACTICAL NURSE (LPN)

A. MAJOR JOB ELEMENTS	B. SUPPORTING TASKS	C. PERFORMANCE STANDARDS
1. Bedside Nursing Care	a. Charts admission vital signs; recognizes, reports and initiates emergency treatment in cardiac/respiratory arrest; observes, reports signs and symptoms of patient's condition; maintains charts and accuracy of intake and output; provides wide variety of patient care activities to include, but not limited to: bed baths; personal hygiene measures; changing beds; wound care; etc. Admits and discharges patients according to SOP.	a. Performs all duties under the direction and supervision of a registered nurse. Performs duties with accuracy. Responsible for reporting all signs and symptoms to charge nurse. Responsible for maintaining all assigned records and accuracy of intake and output. Occasional errors of omission of any single task tolerated during peak work load.
2. Administers treatments and medications.	a. Performs therapeutic measures prescribed by MD such as medications (orally, subcutaneous, intradermally, rectally vaginally, topically). Records administered medications on DA Form 4678. Applies dressings; moist and dry heat; irrigates or intubates selected body cavities. Records treatments on DA Form 4677.	a. Administers medications under the general supervision of an RN with 100% accuracy. Reports all errors to RN immediately. Charts on DA Form 4678 with 100% accuracy. Performs all treatments, irrigations, intubations accurately, safely, and in a timely manner. Any unusual signs and symptoms should be reported to RN immediately. Charts on DA Form 4677 with 100% accuracy.
3. Respiratory Care	a. Administers oxygen, and respiratory therapy, including IPPB, chest frappage and postural drainage. Performs oral and endotracheal suctioning as trained and credentialed.	a. Executes all respiratory care procedures in a safe, therapeutic manner and according to SOP's. Exercises safety precautions when administering oxygen therapy. Knows equipment assembly. Errors in the observation and reporting of mechanical malfunction of equipment will not be tolerated. Treatments will be administered IAW with MD's orders.

PERFORMANCE STANDARDS - 91C/LICENSED PRACTICAL NURSE (LPN)

A. MAJOR JOB ELEMENTS	B. SUPPORTING TASKS	C. PERFORMANCE STANDARDS
4. Cardiac Monitoring	a. Applies proper leads; capable of operating all equipment, recognizes lethal ventricular arrythmias; performs 12 lead EKGs.	a. Correctly applies EKG leads. Is capable of: safely operating all cardiac monitoring equipment, explaining functioning of equipment to the patient to alleviate his anxiety, recognizing lethal ventricular arrythmias on cardiac scopes and immediately initiating resuscitative measures; performing clear 12 lead EKG with accuracy and efficiency. accuracy and efficiency.
5. Infection Control	a. Cares for patients who have infections and are placed in wound, skin, respiratory, enterio and reverse isolation. Maintains isolation techniques. Handles soiled and contaminated linen properly. Washes hands between patients and patient procedures.	a. Knows and understands hospital and ward isolation procedures. Carries out ordered isolation techniques with 100% accuracy. Properly handles soiled and contaminated linens. Knows the importance and practices hand washing between patients and patient procedures.
6. Collects Specimens	a. Performs venipunctures; catherizations and intubations for the purpose of obtaining specimens. Tests urine for acetone and sugar, stools for guiac. Collects: 1) urine specimens for fractional, 2 hr, 24 hr urine tests; 2) Culture specimens (to include throat swab, urine and wound specimens). Transports specimens to lab.	a. Collects all specimens according to ward and/or laboratory SOP. Transports specimens to lab in a timely manner. Collects all specimens accurately using the proper method and proper container. Records collections promptly in the nursing notes. Obtains lab results from the laboratory. Files lab results in correct patient chart in appropriate section. Reports lab results to the charge nurse if receiving a verbal report from the laboratory.
7. Nursing Supportive Measures	a. Provides nursing supportive measures for psychological and physiological and emotional well being of the patient and his/her family. Physical supportive measures include, but are not limited to changing bed linens; changing patient's position; giving back rubs; doing change of motion; giving feeding assistance, oral hygiene; hair and nail grooming; etc.	a. Understands and is sensitive to the fact that a person's behavior may change when he becomes ill and that illness is a stress for the patient and family members. Takes measures to provide patient comfort by utilizing various nursing care activities. Postponements of any single task are tolerated if work pressures so dictate; however, habitual

PERFORMANCE STANDARDS: 91C/LICENSED PRACTICAL NURSE (LPN)

A. MAJOR JOB ELEMENTS	B. SUPPORTING TASKS	C. PERFORMANCE STANDARDS
5. Nursing Supportive Measures (Continued)		(Continued) a. postponements or neglect of detailed care or discourtesy to patients is not tolerated. Utilizes interpersonal skills in providing psychological and emotional support. Treats all patients and their families with concern and courtesy.
6. Ward Maintenance	a. Performs general maintenance duties such as cleaning and arranging supply cabinets and cupboards; handling of soiled and clean linens; concurrent and terminal cleaning of beds, tables and chairs; and cleans and cares for equipment and supplies.	a. Understands principles of aseptic technique and infection control and executes all cleaning procedures according to ward and hospital SOP. Understands the necessity of clean and neat environment for patients. Postponements will be tolerated insofar as work pressures interfere or ward function is not impaired. Cleaning duties will need to be completed before shift change.
7. Transport/escort duties/ chaperoning	a. Performs such needed duties as transporting and escorting patients to other areas of the hospital for treatments and appointments and serves as an attendant and/or chaperone for patients as needed. Transports patients safely, always lifts footrest of wheelchair out of the way before the patient steps out of wheelchair. Drapes and positions patients properly when chaperoning or serving as an attendant.	a. Properly transports or escorts patients as needed or when assigned. Utilizes 100% of the time correct safety measures when transporting patients by litter or wheelchair. Properly drapes and positions patients taking into consideration the exam and patient's comfort.
8. Patient Safety	a. Insures patient safety by supporting patient when walking, through use of siderails, restraining belts with wheelchair patients and restraining straps with litter patients.	a. Understands and actively practices safety precautions; properly utilizes devices to prevent patient injury.

PERFORMANCE STANDARDS: 91C/LICENSED PRACTICAL NURSE (LPN)

A. [illegible] JOB ELEMENTS	B. SUPPORTING TASKS	C. PERFORMANCE STANDARDS
1. Operates Equipment	a. Operates and assembles commonly and frequently used equipment.	a. Safely and properly assembles and operates all commonly used equipment after being shown how to do so.
2. Basic Life Support	Prefers basic life support and CPR as necessary.	Annually certified in CPR by either the American Red Cross or the American Heart Association. Knows the location of CPR cart and oxygen equipment; knows operation of emergency resuscitation equipment to include EKG machine.

END

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