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CLINICAL NURSING RECORDS STUDY

FINAL REPORT

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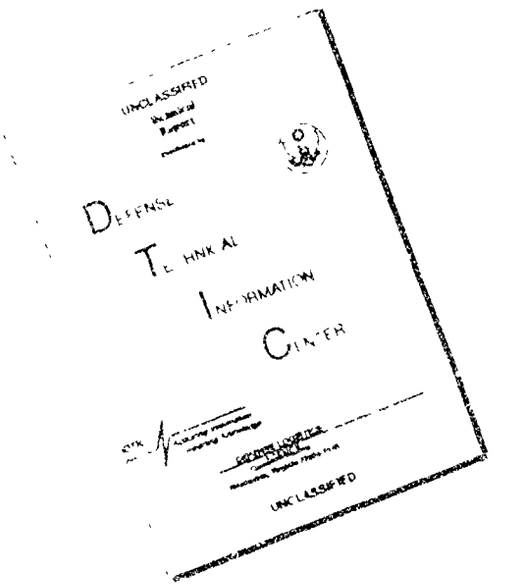

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Study assigned as part of the FY 84 AMEDD Study Program; examined inpatient nursing documentation issues, testing new documentation forms and concepts. The study purposes were twofold: assess AMEDD nursing documentation system to identify specific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

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

SUMMARY

In recent years general dissatisfaction had been verbalized within the Army Nurse Corps regarding the inpatient nursing documentation system introduced in 1977. Numerous operational difficulties were encountered when forms were released to facilities with minimal guidance. The entire system was perceived to substantially increase the amount of "paperwork" nursing staffs were required to complete to adequately document nursing care. A 1981 ad hoc committee for clinical nursing records proposed revisions and recommended testing of revised forms. The study, assigned to Health Care Studies and Clinical Investigation Activity as part of the FY 1988 Army Medical Department (AMEDD) Study Program, expanded the emphasis to include all inpatient forms currently used in Army medical facilities. It evaluated system problems, developed, implemented and assessed tested changes based upon the initial needs assessment. The study was conducted over a four year period; implementation was conducted at four AMEDD hospitals within the continental United States (CONUS): Fitzsimons Army Medical Center, and the Medical Department Activities at Forts Campbell, Jackson and Polk.

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

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

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

Working and advisory groups formed in Phase Two placed priorities on revision, rather than total overhaul, of the documentation system. Efforts centered around solving physician order transcription problems, decreasing redundancy and fragmentation, revising specific forms and developing a standardized educational program and guidelines to accompany implementation. Five revised and three new forms were tested. In addition to revised history, assessment and care plan formats, the use of a coding system on revised

therapeutic documentation care plans (TDs) to indicate efficacy of intervention was also tested. Testing further included separation of medication and nonmedication orders on physician order sheets. Transcription of certain orders to revised TDs was eliminated because of the order sheet format. A standardized format was defined for a nursing discharge summary form; and the group chose to test the integrated note for all disciplines.

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

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

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

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

NOTE: References will be made throughout the following report to standards set by the Joint Commission on Accreditation of Hospitals. Although the title of the organization has subsequently been changed to the Joint Commission on Accreditation of Health Care Organization (JCAHO), the study was conducted during the period when the organization was referred to by its former title. Hence, the reference within this report to "JCAH" rather than "JCAHO."

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

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

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

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

MRB

STUDY REPORT
CLINICAL NURSING RECORDS STUDY

1. INTRODUCTION

a. Background. Documentation of patient care by nurses finds its roots early in nursing history. In 1859, Florence Nightingale (1957) advocated a system which fostered shared information among care givers to ensure that "all will go on as usual" in the absence of one specific party (p. 25). Neiderbaumer (1984) emphasized that documentation of nursing care should be integrated, patient centered and problem solving in focus. Today, nursing documentation serves multiple purposes, including: a communication tool regarding the patient's clinical condition for all care providers; a basis for planning, facilitating continuity and evaluating care; a legal document; a record of quantifiable nursing activities for workload considerations; and a tool to calculate levels of patient illness, i.e., patient acuity (Neiderbaumer, 1984).

Nursing documentation reflects current nursing practice patterns based on planned nursing care. Planned care, in turn, is predicated on identified patient problems and written goals, more formally referred to as the nursing process: "an orderly, systematic manner of determining the...problems, making plans to solve them, initiating the plan or assigning others to implement it, and evaluating the extent to which the plan was effective in resolving the problems identified...." (Yura & Walsh, 1978, p. 20).

While the nursing profession moves toward common definitions and standards for documentation, there are no universally accepted formats for information. Standards of nursing practice specify some criteria, but there is no easily reached agreement as to what is needed, when, in what format, and by whom. Documentation requirements differ with the patient type, acuity, age, hospital status (inpatient or ambulatory care), and by a facility's organization of nursing, e.g., team approach, primary care, case management, etc.

Nursing documentation in the Army Medical Department (AMEDD) has been controversial. In recent years, general dissatisfaction with methods of nursing documentation in AMEDD facilities had been expressed by Army Nurse Corps (ANC) officers. The volume of requests for "exception to policy" and for the use of locally developed overprints and flowsheets suggested the magnitude of the problem. Further emphasizing the problem, in 1981 an Ad Hoc Committee for Clinical Nursing Records at the Office of the Army Surgeon General (OTSG) proposed revisions and recommended testing of revised forms. The study was assigned to the U.S. Army Health Care Studies and Clinical Investigation Activity (HCSCIA) as part of the Fiscal Year 1984 AMEDD Study Program. Emphasis was expanded to examine all inpatient forms used by nursing personnel and to revise and test new forms as necessary.

b. Problem Statement Elements of the current AMEDD nursing documentation system (Appendix A) were introduced in 1977 changing a system in effect since World War II. (For clarity in this text, these forms will be referred to as the "1977 Forms.") The 1977 changes were prompted primarily by revisions in Joint Commission on Accreditation of Hospitals (JCAH) standards which required documenting elements of the nursing process; pharmacist review of physician

orders; and authenticating, with date, time and initials, the performance of "ordered" activities. Because of advancing technology, AMEDD pharmacies were able to offer "unit dose" services which meant that pharmacy, rather than nursing personnel were responsible for individual patient drug preparations. Consequently, pharmacy personnel required direct access to a copy of the physician orders. A brief summary of the major 1977 changes follows.

Department of the Army (DA) Forms 3888, Nursing Assessment and Care Plan (Appendix A-2) and 3888-1, Nursing Assessment and Care Plan, Continuation (Appendix A-4) were to provide structure for documenting the assessment and planning elements of the nursing process. DA Form 4256, Doctor's Orders (Appendix A-6), a three copy form, was to provide copies of the original order for pharmacy review; it did not, however, provide space for nursing personnel to account for order completion. Hence, DA Forms 4677, Therapeutic Documentation Care Plan, Nonmedication (Appendix A-7) and 4678, Therapeutic Documentation Care Plan, Medication (Appendix A-9) ("TDs") were initiated to ensure dating of medication administration and performance of other nursing interventions and health care provider orders. Because the original order and subsequent notation of its completion appeared on separate sheets, every order written by the physician had to be transcribed to other forms to complete the documentation process.

Although written policy and procedures on nursing records were outlined in Army Regulation (AR) 40-407, Nursing Records and Reports (DA, 1979), and DA Pamphlet 40-5, AMEDD Standards of Nursing Practice (DA, 1981), the documents were published several years after form implementation. Consequently, personnel were required to integrate the 1977 system without benefit of written guidelines, leading to personal interpretation with a loss in system-wide standardization.

Through formal and informal communication channels, problems generic to the new system were identified by nursing, administrative and medical staff. Since forms were developed independently of each other, they appeared to lack integration. Implementation difficulties, particularly for specialty areas, were repeatedly cited by chief nurses. The entire system was perceived to substantially increase the amount of "paperwork" nursing staffs were required to complete to adequately document nursing care. Other complaints emphasized that forms were too lengthy, took too long to complete, and were redundant. Information was fragmented. Prompt and easy access to patient information was difficult. The burden of transcribing all orders added to the lengthy process and compounded practice errors. Finally, in many instances, hospital personnel were unaware of JCAH standards revisions, which meant that reasons behind the documentation changes were unknown. This further added to implementing difficulties for the 1977 system.

Dissatisfaction was widespread. To modify the forms, and facilitate the documentation process, requests for exceptions to policy and approval of overprint data on the new forms were submitted to OTSG. Overprints were requested for "standing orders" (thus decreasing transcription requirements), and nursing assessments, to make the assessment and care plan forms more applicable to areas dealing with specialty patients. Additionally, the overprinted requests included "flowsheet" formats, such as those relating to frequently measured physiologic parameters or patient instructions, which simplified documentation necessary to meet the JCAH order accountability requirement.

In summary, the system of AMEDD nursing documentation was perceived to contain inadequacies and ambiguities and lacked integration. The general dissatisfaction served as an impetus for the creation of multiple local systems of documentation which lacked uniformity, continuity, and interrelatedness.

c. Purpose. The purpose of the current study was to assess the AMEDD nursing documentation system to identify specific problem areas and develop forms and guidelines to address the problems. The study findings were believed critical for revision of Army regulations governing inpatient documentation, and to facilitate documentation of patient care providers.

d. Objectives. The objectives of the current study were to:

1) Conduct an in-depth assessment of the current AMEDD nursing documentation system used in fixed facilities to:

a) identify system problems;

b) identify potential solutions to problems;

c) set priorities for problem resolution;

d) develop and field-test documentation changes based on identified system problems.

e) recommend regulation and form changes based on study results.

2. Assess the attitude of AMEDD personnel toward tested documentation changes.

3. Examine the impact of the changes on the quality of records as assessed by JCAH and U. S. Army Health Services Command (HSC) Inspector General (IG) nurse surveyors.

4. Assess the tested changes for practicality in daily use, effectiveness in facilitating the nursing process, and feasibility for worldwide implementation.

e. Study Questions. The current study was designed around the following questions:

1) What do Army nursing personnel, regardless of specialty, identify as problems with the current AMEDD inpatient system of documentation?

2) What do AMEDD nursing personnel suggest as solutions to identified documentation system problems?

3) What are study priorities, based upon identified system problems?

4) What documentation changes can be made to address priority problems?

5) What methods are to be used to test documentation changes?

6) In the opinion of test site personnel, how do the tested elements compare with previously used documentation methods?

7) In the opinion of nurse surveyors from offices of the JCAH and HSC IG how do the tested elements compare with previously used documentation methods?

8) How satisfied are test site personnel with documentation changes?

9) In the opinion of test site personnel, what changes should be made to tested elements prior to worldwide implementation?

10) How practical are the tested elements for daily use?

11) How feasible are the tested elements for worldwide implementation?

f. Assumptions. The following assumptions were made:

1) JCAH and AMEDD nursing practice standards would not appreciably alter during the study period; therefore, proposed documentation changes would comply with current standards.

2) When users are more satisfied with a tested system, perceiving it to better meet their needs than previously used forms, they are more willing to comply with documentation requirements.

g. Limitations. Study limitations were:

1) While independent medical record reviews were conducted by JCAH and IG nurse surveyors using their respective standards, the issue of "quality" of the patient record was addressed from the user perspective.

2) Assessment of the "quality" of documentation, unless defined in an auditable, objective manner (e.g., "were all the blocks completed?"; "did the nurse sign the care plan?"; "were the guidelines followed?") was, to a large extent dependent on the user's clinical background and experience.

3) Medical record "quality" is affected by numerous intervening variables (e.g., staffing patterns, command emphasis, scheduled outside surveys, individual facility quality assurance/risk management programs, staff education classes) which were not controllable for the study purpose.

4) Responses to the request for study input were unstructured. Local facilities determined the process by which comments were solicited from nursing personnel and subsequently forwarded to investigators at HCSCIA.

2. LITERATURE REVIEW

Documentation issues and the theoretical framework used during study phases is described in this section.

a. Documentation Issues. Use of the nursing process is advocated by professional nursing organizations, e.g., the American Nurses Association and the National League for Nursing. Documentation of the process in the AMEDD is governed by AR 40-407, Nursing Records and Reports and DA Pamphlet 40-5, The AMEDD Standards of Nursing Practice. In addition, The Army Surgeon General mandated that Army medical treatment facilities would comply with standards for hospitals specified by JCAH which dictated documentation of the nursing process in the patient record.

Documentation is one of the first skills learned by nursing personnel at all levels, regardless of civilian or military perspective. Yet it is also one which, in the current environment of advancing technology, increased requirements from regulatory agencies, and staffing shortages, often receives a low priority on nursing units (Barbiasz, Hunt, Lowenstein, 1981; Costello and Summers, 1985). Nursing documentation problems are not new; however, the increase in their scope and variety are evidenced by the numerous discussions in the literature regarding the nursing process, nursing care plans and the audit of nursing records (McClosky, 1980; Huckaby and Neal, 1979; Creighton, 1980; Barbiasz et al, 1981; Weeks and Darrah, 1985; Bartos and Knight, 1978; Roeder, 1980; Lampe, 1985; Costello and Summers, 1985). Over the past ten years, JCAH had steadily increased documentation standards. With recent third party reimbursement for Medicare and Medicaid patient care via Diagnosis Related Groups (DRGs) sufficient nursing documentation has taken on new perspectives. The old adage of "if it's not written down, it hasn't been done" is applied not only to quality of care issues, but also to revenue concerns.

b. Innovation Theory. Early in proposal development it became evident that study activity would involve introducing new documentation concepts to study site personnel. Investigators sought to minimize difficulties previously encountered with other documentation changes through an understanding of the change process. Innovation theory was determined to be highly relevant to study methods.

Barnett (1953) distinguished an "innovation" from many forms of "change." Often, a change had no resemblance to its predecessor. It frequently could be an entirely different concept, direction, etc.; used by, or created for, an entirely different group. An innovation, on the other hand, closely resembled its antecedent, with only some modification, and could subsequently be used either by the same group, or a totally different group. Barnett (p. 10) maintained that it was this "reorganization," or substitution of parts, which thus created the innovation.

Innovation theory has its roots in the social sciences and anthropological literature. While containing elements of change theory models as proposed by Lewin (1953), and of planned change advocated by Bennis, Benne, and Chin (1961), the perspectives of innovation theory (Barnett, 1953; Kushner, 1962; Rogers & Shoemaker, 1971; and Spicer, 1952) identify that all innovations "...follow a predictable evolutionary course. An innovation may be accepted or rejected; it may find only gradual support from potential adopters during its early phases of development and be adopted only after the passing of time. . ."

(Lundsgaarde, Fisher and Steele, 1981, p. 4). Situational or contextual features figure prominently in its subsequent acceptance or rejection by users:

> . . . the reception given to a new idea is not so fortuitous and unpredictable as it sometimes appears to be. The character of the idea is itself an important determinant. . . Also, when an innovation . . . makes its appearance, it does not do so in a vacuum. There are certain situational features connected with it which predispose those to whom it is introduced either to accept or reject it . . . the values placed upon these features may either reinforce or nullify each other . . . (Barnett, 1953, p. 313)

The processes of innovation acceptance or rejection are complex, often a function of time (Lundsgaarde, et al., 1981, p. 4). Lundsgaarde and his associates (1981) used innovation theory as a guide while investigating factors which influenced user reaction to an automated documentation system. They identified variables postulated to affect the acceptance of an innovation. While not axiomatic, their propositions helped to focus their study on the numerous human and organizational problems which arose during implementation of the system (Lundsgaarde, et al., p. 5). They proposed, that to be accepted, an "innovation" must:

- be associated with some previous experience on the part of persons who accept it;
- prove rewarding to those who will use it;
- show a clear and unambiguous improvement over its antecedent ideology and technology;
- prove to be workable in the environment into which it is introduced (Lundsgaarde, et al., p. 5).

The innovation is more/most likely to be accepted/adopted/viewed favorably:

- if it enables users to link the innovation with desirable changes in attitudes, values, and operational procedures;
- if it can be adapted to existing practices without any loss of prestige or authority on the part of those who adopt it;
- if its acceptance increases the relative prestige of the person who adopts it;
- by those who may have less to lose and more to gain by adoption;
- by persons whose social status and traditional positions in the social or professional hierarchy are not threatened by the introduction of a new system or procedure.

- if it does not conflict with individual or group values;

- if people who experience the change are involved in the implementation of the innovation;

- (and diffused rapidly) if high prestige individuals actively use and promote the acceptance of the innovation itself (Lundsgaarde, et al. p. 5).

They continued: an innovation:

- is accepted or rejected on the basis of how its perceived or actual utility compared to previous practice;

- which may be more efficient than its predecessor, may not necessarily be adopted if a former practice or technology continues to have intrinsic value for its users;

- adoption may depend on the origin or direction of the innovation from one group to another;

- may be opposed, directly or indirectly, by individuals and groups who perceive that it will detract from their present authority and prestige within the social system;

- is invariably modified to accommodate existing or traditional practices (Lundsgaarde, et al., p. 5).

In summary, Lundsgaarde and colleagues' propositions were based on user perspectives. Innovations emanating from the user levels, couched in familiar terms, with more perceived positive than negative effects, and which were found to be helpful to the user's situation and environment enhanced acceptance. The theory and aforementioned Lundsgaarde "propositions" influenced all methods of the current study.

3. OVERALL METHODOLOGY AND REPORT CONTENT

The study was conducted in four phases over a four-year period. In Phase I investigators assessed specifics regarding perceived documentation problem areas. Study priorities and strategies were identified in Phase II. Proposed documentation changes were implemented in Phase III; their affect was assessed in Phase IV. The study phases had few distinct start and end points. Some overlapped into time designated for subsequent phases.

Findings from one phase influenced the methodology of subsequent phases. Phase I findings reflected responses received from AMEDD nursing personnel regarding documentation issues. Phase II findings included the priorities established by working group members, forms, guidelines and programmed text developed for test. In Phase III, implementation issues common to each site were identified. By survey, Phase IV collected IG and JCAH results.

Because of the complexity of the study methodology, and the influence of each phase's results on subsequent study activities, for clarity, the methods

and findings for each phase are reported in the same chapter. Discussion and general recommendations follow in separate segments.

4. PHASE I

a. Methodology. A letter (Appendix B-2) was sent from the Chief, ANC to AMEDD nursing personnel worldwide soliciting comments regarding perceived problem areas with the AMEDD inpatient nursing documentation system and potential problem solutions. Chief nurses were also asked to indicate interest in having their facility serve as study test site.

Responses were not structured. Subsequently, common issues of concern were identified by content analysis. Responses were received from 51 out of 52 AMEDD hospitals worldwide. Local methods used to gather input from nursing personnel varied: formation of committees to articulate concerns; the appointment of one officer to collect and collate comments prior to forwarding responses to the investigators; questionnaires; and the forwarding of individual suggestions directly from nursing staff members. Suggestions for change often arrived as sample copies of forms described in an accompanying letter. Because of the varied response formats, data were collated to identify commonalties of problem areas specific to each form and AR 40-407 (the regulation governing nursing records), and remarks regarding the documentation system as a whole.

While awaiting responses, investigators gathered information regarding documentation systems in use at other federal hospitals. Civilian institutions across the United States identified as having exceptional documentation systems by the Magnet Hospital Study (American Academy of Nursing, 1984), and by JCAH nurse surveyors were also queried and shared documentation forms and policies with investigators.

b. Findings. Using content analysis, responses were grouped by commonalties of problem areas specific to each form and AR 40-407, and remarks regarding the documentation system as a whole (Appendix C).

In summary, perceived problem areas of documentation included:

- issues related to directions for clinical record use. For example, the numerous policies and regulations governing records were not perceived as clear, specific or as concise as was required for consistent implementation. Respondents identified the need to have one set of regulations which addressed the clinical record as a whole rather than having regulations which fragmented documentation information by provider, e.g., physician or nurse, or provided service, e.g., pharmacy.

- issues related to the DA Forms 3888 and 3888-1 (nursing history, assessment and care plan formats) such as the awkward wording of questions, inadequate space for patient responses and nursing problems, and recording care problems and subsequent nursing actions on separate sheets. Respondents also identified that much of the information appearing on these forms was data found elsewhere in the patient record. The history and assessment form was perceived as not applicable to

specialty areas such as pediatrics, obstetrics, psychiatry, but reflective of information from an adult medical or surgical area.

- the necessity of transcribing all orders appearing on DA Form 4256 to another form. This was perceived by respondents as time consuming, cumbersome, and creating increased chances for error.

- information appearing on DA Forms 4677 and 4678 (the Therapeutic Documentation Care Plans, Nonmedication and Medication, respectively) was perceived as serving only the purpose of indicating performance or nonperformance of an order. Respondents identified that repeated documentation of the same order often resulted when an order was transcribed to the forms, then initialed when carried out, and subsequently recorded in narrative nursing notes.

- the lack of a standardized discharge format for documentation of nursing care.

- the lack of standardized specialty area flowsheets (e.g., critical care, newborn nursery).

- the overall redundancy in the medical record.

- fragmentation of patient progress documentation.

Suggestions for change included:

- revision of regulations governing documentation.

- restructure of DA Forms 3888 and 3888-1 (e.g., include overprinted assessment guidelines; expand the nursing care plan, eliminate the requirement to collect data contained elsewhere in the medical record).

- redesign DA Form 4256 to eliminate the need to recopy physician's orders.

- expand DA Forms 4677 and 4678 to allow use of a a coding system to indicate the efficacy of nursing actions directly on the forms.

- utilization of the Standard Form (SF) 509, Progress Notes, by all nursing personnel, in lieu of SF 510 (Nursing Notes), for multidisciplinary documentation.

5. PHASE II.

a. Methodology. A working group composed of ANC officers (Appendix D-2) was convened to review responses and identify study priorities, necessary strategies and tools for evaluation. Group members were primarily assigned to hospital inpatient units and included clinical staff and head nurses, a staff development instructor, and quality assurance officer. They represented varied clinical specialties: medicine, surgery, psychiatry, pediatrics, obstetrics,

gynecology, and critical care. Operating room and anesthesia representatives were excluded because their subspecialties had forms in test at the same time as the current study. Additional ANC officers in staff positions, e.g., the HSC IG, and Nursing Science Branch of the U.S. Army Academy of Health Sciences (whose personnel were responsible for teaching AMEDD documentation elements to newly commissioned officers and enlisted personnel), were also included in the group. Members provided a diverse group which could recognize common needs across all specialties, yet reflect on the applicability of devised strategies within a specialty.

Advisors to the working group included representatives from various divisions at HSC (Appendix D-3). The working group sought consultation on matters dealing with form development/revision, regulation changes, medical records, and medical-legal documentation considerations.

In preparation for the group work, members received copies of the content analysis prepared from Phase I, and attended briefings regarding documentation issues. The investigators provided a historical perspective on documentation systems in the AMEDD, development of the system under discussion, and examples of civilian documentation systems which had been explored prior to group formation. The Study Director addressed the perspective of documentation from the major command and local facility level. Members of the HSC IG office discussed recent survey findings, and documentation requirements. A representative from the Tri-Service Medical Information System (TRIMIS) Project Office addressed planned automation changes and considerations to enhance compatibility between any "hard copy" forms the group might develop and automation requirements. Discussions were also held with personnel from medical records, pharmacy, and quality assurance services at HSC and Brooke Army Medical Center (BAMC), and JCAH nurse surveyors. Finally, group members spent three sessions reviewing all comments, discussing identified difficulties, and establishing the group process.

Members were divided (based upon their areas of interest) into subgroups tasked to redesign forms and draft guidelines governing form use. A third subgroup developed an educational program to be used by test site personnel during implementation. Subgroups met as necessary to complete tasks. The main group reconvened approximately every four to five weeks to review subgroup work. All group work was accomplished over a nine month period.

Group members chose to direct their work towards revision of the system rather than creation of a new documentation scheme. AMEDD nursing documentation, even with its flaws, contained several positive elements. The concepts and philosophy of the AMEDD Standards of Nursing Practice and required nursing documentation reflected "state-of-the-art" nursing practice. Eliminating the requirements for a nursing history, assessment, and care plan was neither possible nor desirable. Members also reaffirmed the necessity of having a mechanism for the writing of nursing orders which reflected nursing actions. The TDs provided that mechanism. An AMEDD developed patient classification system was to be introduced to all Army facilities within a year of completed group work, and members recognized the necessity of providing a form for nursing orders which could also be used for that purpose. Finally, the separation of medication from nonmedication activities on the TDs was considered a valuable aide to identifying tasks with a minimum of confusion. Separating medication orders for accountability also facilitated the administration of medication for each patient.

Propositions of innovation theory (Lundsgaarde, et al., 1981) also influenced the decision to revise rather than totally change. The desire to preserve the positive aspects of the system was linked to the knowledge that innovations were more likely to be accepted, for example, when associated with a previous experience or adapted to existing practices without any loss of prestige or authority. Acceptance was also associated with innovations that were not in conflict with values and which could be viewed as an alternative to traditional usage. In addition, knowing that the "innovations" developed by the working group would be measured against how their perceived or actual utility compared to previous practices by users, group members were further convinced that while revisions were essential, total change of the system was not a requirement.

Other parameters influenced the group's decision to revise rather than create. A costly chartback system had been purchased by Army MTFs to accommodate the inpatient medical record forms. A total revision of forms necessitating a new chart container was not economically feasible. It was also recognized that an automated record was an eventuality for the AMEDD. "Hard copy" charts would be replaced by computerized data files. Nursing personnel would be required to adjust to another complete documentation change. Rather than introduce two totally new systems within the space of a few years, group members decided that revisions made to the current system, with the introduction of as few "new" forms as possible, might prove more acceptable. However, members recognized that regardless of proposed changes, a "hard copy" record would still have a degree of redundancy and fragmentation. While automation would be the best answer, any simplification of documentation requirements, and integration of information in a manually written form, would begin to address some of the issues raised by nursing personnel.

While group members were completing their work, investigators contacted the 18 chief nurses within HSC who had indicated interest in having their medical treatment facilities (MTF) further involved with the study. Following discussions with their commanders, 15 chief nurses informally notified the investigators that their commanders were willing to invite study personnel to their respective facilities. A letter (Appendix D-4) was sent from the Commander, HCSCIA to the facility commanders formally requesting access to the MTFs. Additionally, specific information was requested (Appendix D-6) for use by study personnel to coordinate required logistics and select study sites. Information included facility demographics (bed size, catchment area, patient population, services provided, etc.), educational and typing resources within the Department of Nursing, form use estimates, and unique facility characteristics which, in the opinion of local personnel, might enhance or impede study logistics.

Testing was originally planned for eight sites. Because of budgetary constraints the study was limited to four MTFs representative of HSC facilities. Criteria to ensure representativeness were based on previously described demographics, and also included case mix indices identified by HCSCIA researchers conducting case mix analyses of Army inpatient data. Additionally, three of the test sites were involved with another HCSCIA study (i.e., ambulatory care data base study). It was felt that site visits by investigators to these MTFs could accomplish multiple purposes. Test sites for the current study were: Fitzsimons Army Medical Center, Aurora, Colorado; Bayne-Jones US Army Community Hospital, Fort Polk, Louisiana; Blanchfield U.S.

Army Community Hospital, Fort Campbell, Kentucky; and Moncrief U.S. Army Community Hospital, Fort Jackson, South Carolina.

At the completion of form and guideline development, prior to printing and implementation, the Study Director and Investigator consulted with two JCAH nurse representatives: one from the central office who was responsible for answering questions regarding standard interpretation, and another who trained the nurse surveyors. Forms and guidelines were reviewed in the context of meeting JCAH requirements for nursing documentation. While the JCAH, as a matter of policy, does not endorse any specific form used by an individual facility or organization to document patient care, the representatives indicated that, as drafted, the guidelines and purposes of proposed forms appeared to be in concert with quality assurance and medical record requirements. They encouraged the study's focus on the problems of redundancy and fragmentation in the clinical record.

A two day pretest of forms was completed by nursing personnel on three nursing units at an Army medical center in Texas. Their comments and suggestions regarding clarity of questions on the nursing history form, and portions of the guidelines were incorporated prior to printing.

Additional chart dividers were required to separate physician order sheets within the record. Ordering of the dividers was coordinated by the investigators directly with the Carstens Medical Products company, whose charts were in use at AMEDD facilities worldwide.

Printing and distribution of forms, guidelines, and instructional material were coordinated through OTSG and DA levels. Printing was accomplished via the Government Printing Office (GPO). Appendix D-8 graphically portrays the numerous levels through which the materials were required to pass prior to distribution to test sites. The printing and distribution process took eleven months.

b. Findings.

1) Priorities. The working group chose to address priorities having the broadest scope for all AMEDD nursing personnel. Based upon data contained in content analysis summaries, the Phase II priorities were: physician order transcription; documentation redundancy and fragmentation; revision of the nursing history, assessment and care plans; development of a standardized nursing discharge format; and development of a standardized educational program or guidelines to implement any form changes.

2) Group Work. The working group was divided into two sections. One focused on changes for the nursing history, assessment and care plan formats, and nursing discharge summary; the other, order transcription and revision of the TDs. Each section's results addressed the redundancy and fragmentation issue. The entire group discussed the concept of having all nursing notes integrated with the progress notes of other disciplines on the SF 509. Group activities are reported by priority or specific form. Significant test form or regulation changes are detailed. Test forms and guidelines are contained in Appendix E.

a) Nursing History, Assessment and Care Plan. Test forms, and accompanying guidelines discussed in this section are: DA Form 3888-2 (Test),

Nursing History and Assessment (Appendix E-2); DA Form 3888-3 (Test), Nursing History and Assessment, continued (Appendix E-4); DA Form 3888-4 (Test), Nursing Care Plan (Appendix E-6). These forms replaced DA Forms 3888 (Nursing Assessment and Care Plan) and 3888-1 (Nursing Assessment and Care Plan, continuation).

Group members concluded that the admission nursing history and assessment should be contained on one sheet of paper, with pertinent, but general, history questions on the front side, and admission assessment data on the reverse. Minimal data required to begin planning nursing care included information about the patient's knowledge of reasons for hospitalization, and usual health and daily living activity patterns. However, instead of 29 questions related to such areas, as appeared on the 1977 edition, DA 3888-2 (Test) contained eight questions which were thought applicable to all patient specialties. Questions soliciting information found elsewhere in the patient's record (e.g., religion, date of birth, alcohol and tobacco use, prior hospitalizations) were eliminated. Data concerning "known allergies" was of such critical importance it was included although asked and recorded by other health care providers. Blank areas were provided for patient response. An area was designated for a local contact, not necessarily a "next of kin" listed on the data card supplied by the hospital administration section.

A section for noting personal articles and valuables kept at the hospital by the patient also appeared on the front of DA 3888-2 (Test). Group members were divided regarding inclusion of such a segment; those in opposition identified that, by regulation, such items were required to be deposited with the hospital treasurer, or if after duty hours, with the appropriate hospital administrative representative, e.g., staff duty officer or noncommissioned officer of the day. Those arguing for inclusion cited that such activities often fell to nursing personnel to accomplish, and it was for patient convenience that dentures, glasses, small amounts of money, etc., were left on the nursing unit. It was decided to test the segment. The accompanying guidelines specified that initialing the disposition of personal articles by the interviewer attested only to where such items were consigned, and would not be interpreted to mean that the interviewer was the person who placed the articles in the designated area.

Finally, there was a section for interviewer's signature. Group members recognized that, while the RN was ultimately responsible for the assessment and care planning, several different levels of AMEDD nursing personnel, including the 91C (licensed practical nurse) were trained to obtain patient information. Additionally, the AMEDD Standards of Practice identified that the nursing history was obtained by "nursing personnel" (DA, 1981, p. 2-2). As such, it was decided nursing personnel other than the RN would also be authorized to complete the history portion of the DA 3888-2 (Test). The form's reverse side contained sections for nursing assessment data, including admission vital signs. Date and time of assessment performance was designed to appear at the page top, followed by the written nursing assessment and the RN signature block. Categories from the AMEDD Standards of Nursing Practice were overprinted on the bottom of the form to serve as an optional guide for the RN. If completed at admission, the history and assessment served as the admitting nursing note; a duplicate note in the narrative progress notes was not required.

A few words are necessary about the overprint issue. Group members were aware that the amount of collected history and assessment data varied by

specialty patient, and often, within the specialty. For example, data obtained on a pediatric patient admitted to a specialty unit at a medical center/teaching facility could be more extensive than that obtained on a pediatric patient admitted to a pediatric unit at a small community hospital. Each Army facility had unique characteristics (e.g., level of provided services, teaching requirements) which often influenced the amount of information to be collected. Consequently, nursing staffs of many AMEDD facilities had designed, and received approval for the use of overprinted material on DA forms. Because such overprints met certain perceived needs at the local facility, it was decided to allow the use of approved overprinted material on the test forms. The DA Form 3888-3 (Test) was designed to provide room for additional history and assessment data, or overprinted material. Its use was optional. Major changes to the nursing care plan (DA Form 3888-4 [Test]) were its expansion to both sides of one form, thus allowing more room for nursing care problems and the overprinting of nursing diagnosis categories to facilitate their use by RNs when describing patient problems. Use of the categories was optional. Permission to use the copyrighted material was obtained from the McGraw Hill Publishing Company. Discharge considerations remained a section on the reverse side of the form.

b) Nursing Discharge Summary. The DA Form 3888-5 (Test), Nursing Discharge Summary (Appendix E-8) was developed for the test period. It had no preceding DA form.

After reviewing local facility developed discharge "overprints", the working group concluded that, regardless of what data was collected when the patient was admitted, there were commonalties among discharge notes. These included: introductory material, such as date, time and mode of discharge; activity levels or restrictions; dietary regimens; medications; treatments or specialty teaching, such as wound care; instructions for follow-up appointments; and general comments regarding the patient's overall condition.

All segments were combined on the DA 3888-4 (Test). Additional space was provided for the RN's signature and other pertinent discharge information. The form was designed to supply three copies: one each for the inpatient and outpatient records; and one for the patient's use.

c) Physician Order Sheets/Order Transcription. Test forms discussed in this section are: DA Form 4256-1 (Test), Doctor's Orders Form for Medications (Appendix E-9); and DA Form 4256-2 (Test), Doctor's Orders Form for Nonmedications (Appendix E-10). These forms replaced DA Form 4256, Doctor's Orders.

The order transcription priority was very complex. Initial revision attempts dealt with developing an order form which would eliminate the need to recopy orders The "ideal order form" would continue to meet all JCAH requirements; be easy to read and use; contain an area for the order and adjacent grids for noting specific dates and times of order completion; require no transcription; and provide a mechanism for medication administration within the unit dose system.

Following lengthy discussions, it became obvious that until the automated medical record was a reality, the "ideal" form in hard copy was not feasible. Space on such a form would allow only four or five orders per page (as opposed to 24 orders/page on the 1977 edition), thus generating a greater mass of

paper. In order to decrease confusion, an "ideal" form would require a minimum of three sections: medication, nonmedication and intravenous solution orders. This concept, while having some merits, was also recognized to be a potential irritant for the physician. Finally, members realized that eliminating the transcription requirement would also eliminate the forms to which orders were transcribed, i.e., the TDs. However, while one problem would be solved, others would be created. Another strategy would be required for the administration of medication in the unit dose system. Even if the form design included multiple copies, from past experience it was known that copies available for the nurses' use were often illegible or unusable for safe medication administration. Therefore, an alternative, e.g., medication card, would eventually involve rewriting of the order. Additionally, the TDs were also used as a mechanism to convey information to other nursing personnel responsible for patient care. Eliminating the forms would effectively remove the tool used by nursing staffs during "end of shift" report. The alternative required review of each patient's chart during shift change, a time consuming and cumbersome process, and one which would limit the record availability to nonnursing care providers during the shift report time.

Short of automation, order transcription could not be totally eliminated. Yet, some orders, because of either their purpose (orders written to cover actions previously accomplished prior to admission or during an emergency) or single action/one time nature (e.g., orders accomplished almost immediately or within the tour of duty when written) were the least necessary to recopy. Such orders would be completed by the time of arrival of the following shift personnel, and therefore not their responsibility. Revised order sheets allowed the performance of "single action orders" to be directly noted on the forms. Single action orders were defined as one-time orders which were completed within the responsible RN's tour of duty and which, once completed, required no further nursing activity. If a single action order was not completed within the prescribed time, it became a "delayed order" and required transcription to the appropriate TD.

Although transcription requirements were reduced, group members remained concerned about the possibility of missed orders and chose to pursue the option of separating medication from nonmedication orders. Such separation was felt to have advantages: enhanced quality assurance procedures; facilitated monitoring and evaluation of drug/drug, drug/food interactions, the use of antibiotics and controlled substances; the identification of "stat/emergent" orders and completed actions by nursing personnel; and provision of a consolidated record for drug profiles. Finally, it was recognized that medication and nonmedication orders would be separated once the medical record was automated. Because of these factors, two triple-copy sheets, which allowed for single action order accountability were developed by the working group. The two forms were color coded: white for medications; green for nonmedications. These colors corresponded to the white (medication) and green (nonmedication) TDs used to account for order performance.

d) Therapeutic Documentation Care Plans. Relevant forms discussed in this section are DA Form 4677-1 (Test), Therapeutic Documentation Care Plan, Nonmedication (Appendix E-11); and DA Form 4678-1 (Test), Therapeutic Documentation Care Plan, Medication (Appendix E-15). The test forms were revisions of DA Forms 4677 (Therapeutic Documentation Care Plan, Nonmedication) and 4678 (Therapeutic Documentation Care Plan, Medication). Revision of the TDs was accomplished by the group members for two reasons: to address the

redundancy and fragmentation priority; and to provide a form to reflect the recopied "delayed orders" on the revised physician order sheets.

A frequently cited complaint about the TDs was the repeated requirement for documentation: transcribing the original order to the sheets; accounting for performance of the ordered activity with nursing personnel's initials; and, as necessary, subsequently noting order results (e.g., effectiveness of analgesic; appearance of wound following dressing change) in a narrative nursing note. As a major change of the current study, the TDs were revised to allow direct recording (with either a coding system or brief description) of order results on the appropriate form. Because of the grid design, it became possible to record up to 14 days of results.

Four codes were used on the medication TD sheet. When only the care provider initials (Code: "Initials Only") appeared in the designated block, the medication/order had been administered/completed. Initials and "E" indicated that the administered medication had achieved the desired effect. Such documentation required no further explanation in the progress notes. Initials appearing with an "I" indicated that the administered medication failed to achieve desired results as specified in the original order. Such a notation required further discussion in the progress notes. Finally, the initials and "O" indicated that the medication had not been administered as ordered. This also required a progress note regarding the reason for omission and subsequent follow-up. Three codes were used on the nonmedication sheet: initials only indicated the completion of the order; initials and "+" indicated that the results of the nursing intervention and/or observation were satisfactory or within normal limits; initials and "O" indicated either the results of the intervention were unsatisfactory, the intervention was omitted, or the scheduled observation went unobserved. Again, use of the "O" code required further documentation.

Nursing personnel were also authorized to record pertinent results data in lieu of code use. For example, if a nonmedication order required head circumference measurements on an infant, the measurement could be recorded in the appropriate date/time grid square.

Color coding of the two sheets was maintained to facilitate order transcription and identification. Recurring, "PRN" (as necessary), and single action orders sections were also retained; however, unlike the original TDs, each section was printed on a separate page. The TDs were redesigned to resemble a folder, which, when closed identified the single orders on the front page, when opened contained the "PRN" orders on the right side and recurring orders on the left, and, when closed and reversed, continued recurring orders. This provided larger grid squares for order notations, increased the numbers of orders which could be transcribed to each section, and increased room for all types of orders.

Each form was similar in structure and purpose: to document order completion and results. Informational content, however, differed for each form. For example, the medication TD referred to "Single Actions, Delayed Orders, Preoperatives" on its single order section, versus the nonmedication TD which simply specified "Single Actions, Delayed Orders." Medication PRN section required the order to specify the PRN medication, dose, route, frequency, and reason; the nonmedication PRN section required the PRN action and frequency.

A final major TD revision was the printing on card stock paper. Because of expanded use, it was projected that the forms would be handled more than in the past, and would thus require sturdier paper stock.

e) Redundancy and Fragmentation of Documentation. Several strategies were developed in the course of test form design which addressed this priority. Elimination of certain questions on the history form and the use of the admission assessment and discharge nursing summary in lieu of admission and discharge nursing progress notes decreased repeated documentation. The ability to record results of nursing interventions directly on the sheet listing the orders provided immediate feedback, keeping similar data in one area, yet not limiting the nursing staff's ability to expand on the activity in the progress notes as necessary for continuity of care. However, the overarching concept which addressed the issue was the use of integrated progress notes.

Integrated progress notes involved having all care providers chronologically document patient progress in one record area, rather than separating nursing notes from progress notes of other disciplines. The integration had been cited as promoting reading of other's notations and reducing redundant documentation in the patient record (Niederbaumer, 1984). Such combined notes had been successfully used by AMEDD psychiatry service personnel in various Army hospital facilities. Nurses in extended care roles such as anesthesia, midwifery, and community health had also integrated their notes with those of other disciplines. However, because of Army regulations, prior to the current study, other Department of Nursing personnel (e.g., head and staff nurses and paraprofessionals) were precluded from recording information on the SF 509 (Progress Notes) and required to record narrative notations on the SF 510 (Nursing Notes). This provided a "source-oriented" record which resulted in duplication of information and required searching of the chart to obtain the entire "picture" of the patient's hospital course.

Several elements were necessary to facilitate the use of the integrated notes by nursing personnel, most importantly, the provision of a "flowsheet" to subsume the bulk of daily routine activity documentation. The TD revisions were projected to provide such a documentation sheet, and thus allow nursing notations in the progress record to reflect deviations from normal responses, summative statements covering multiple activities, daily physical assessment data, etc. Identification of the note's source was accomplished by having nursing personnel precede each notation with the nursing care plan ("NCP") problem number to which the note referred, or the statement "Nursing Note." Nursing personnel were encouraged to read the previous entries written by other disciplines to avoid duplicating information and to remain informed.

Guidelines (Appendix E-21) governing the use of the integrated progress note included segments on the format, frequency and content of notations. The guidelines also specified that all nursing personnel were authorized to chart on the SF 509 and specifically addressed review of progress notes by the charge nurse and student documentation.

f) Test Form Guidelines and Programmed Text. To provide for minimal personal interpretation, guidelines for all test forms used were prepared and distributed with the DA implementing directive authorizing the study implementation. Guidelines were written by the same group members responsible for specific form design. Final edit was completed by the

investigators. In addition, a linear programmed text (Appendix E-65) was adapted from the guidelines to further enhance a standard implementation effort at all facilities.

6. PHASE III

a. Methodology. Significant components of this phase included: project officer training; site preparation; site implementation; investigator follow-up; and on-going site activity (Appendix F). Details are chronicled by respective project officers in Appendix G. General methods are outlined in this segment.

1) Project Officer Training. While awaiting the completion of study materials' printing and distribution, chief nurses at each test site were requested to appoint a project officer who would serve as the point of contact for the local facility, through whom all site logistics, local implementation plans, questions, and other issues germane to the study operation were coordinated. Chief nurses were guided only by the request that the appointed person have access to all areas of the hospital's operations and not likely be reassigned on a permanent change of station to another AMEDD facility during the study's course. Appointed ANC officers' positions differed; however, each officer was one whose position and abilities facilitated positive interaction between clinical, administrative and support services required by the study methods. Project officers included: Quality Assurance/Risk Manager (FAMC); Chief, Clinical Nursing Service (Ft Polk) and Nurse Methods Analysts (Fort Campbell and Fort Jackson). Chief nurses were also requested to appoint two additional personnel to assist the project officers with training requirements and implementation issues.

In preparation for site implementation, project officers and their staffs attended a week-long training session at Fort Sam Houston, Texas, in June 1985. They received briefings similar to those given to working group members in Phase II. The study's historical perspective, and priorities were reviewed; Inspector General and JCAH documentation issues were discussed, etc. Attendees learned of each stage of form development, why some options were rejected by working group members, and others further expanded. Each form, and its applicable guideline was reviewed in detail. This training provided project officers with answers to questions likely to arise during site training and implementation.

Project officers returned to their facilities to plan implementation, and reconvened with investigators in October 1985, immediately prior to site preparation to review implementation plans. This also provided an opportunity for final questions and issue clarification.

2) Site Preparation. Project officers were responsible for coordinating all training at each site. They were provided with educational material, including a programmed text, transparencies for classes, and information papers describing the study, prepared by the investigators, for various groups of hospital personnel (Appendix F). However, to facilitate training, except for forms, guidelines and programmed text review, the teaching program was structured by the site project officer and trainers who were in the best position to identify facility needs and appropriate types of inservice education. Test forms and guideline use affected numerous levels within the facility; therefore, classes and briefings were conducted for other

professional and administrative staffs, as well as nursing personnel. Scheduling of classes was under the purview of the individual project officer.

Prior to implementation of the forms, distribution logistics were coordinated between the project officers, local forms managers and wardmasters to ensure adequate supplies of forms on nursing units. Chart dividers were also distributed to wardmasters for inclusion in patient charts on the first day of form implementation.

3) Site Implementation. Minimal delay was experienced between scheduled classes and forms implementation. Actual use of the forms began within two weeks of all class completion. Test forms and guidelines were used on all inpatient units for a period of four months. Days one through 30 were designated as a phase-in period: all patients admitted to the facility had new forms placed in their records; patients admitted prior to Day One had their charts gradually converted to new forms, unless they were to be discharged within the first two weeks. It was originally planned to have records of any remaining patients converted by the end of the 30 day phase; however, all patient records at each site were converted to test forms within two weeks of the start date which kept dual records system to a minimum. Thus, by the end of the first month, all inpatient records reflected the new test forms. Copies of test forms, guidelines and the DA implementing directive authorizing test material were kept on file in each facility's medical records section.

FAMC and Ft Jackson completed training in November and implemented test forms in December 1985. Forts Campbell and Polk completed training in December and January, implementing forms in January 1986.

4) Investigator Visits. Two investigators visited each site during the first test month to meet with staff members and answer questions about the entire study. In addition to meeting with nursing and administrative personnel, meetings were held with facility commanders. Investigators spent from three to five days at each site and visited all nursing units at least once during the day, evening and night shifts to avail themselves to hospital personnel working alternate shifts. Investigator's activities were planned by project officers to allow maximum exposure to facility personnel. Trip reports were written and distributed to all test sites to identify common issues for clarification, as well as communicating various strategies which appeared to be successful with implementation problems.

5) On-going Site Activity. Project officers and trainers repeated training programs for newly assigned personnel. Additionally, training was required on a recurring basis for reserve component, contract and student personnel. Most training was conducted in large groups. One facility developed a video tape for use during subsequent training sessions.

At the end of the four-month trial period, all sites elected to continue use of test forms for the remainder of the authorized two year period. The decision to continue was made jointly by nursing, command and clinical services staff. Form use estimates were revised; additional forms were ordered, printed and distributed via the same process outlined in Phase II. Guideline and programmed texts were locally reproduced by each facility on an "as needed" basis.

b. Findings. Details of site-specific implementation activities are found in Appendix G, Project Officer Reports. However, several issues common

to all sites: misprinted forms; lack of forms; overprints; inability to use a yellow highlighter to discontinue orders; questions regarding form use, are discussed in this segment.

1) Misprinted Forms. Following the 11 month printing process, forms were shipped directly from the GPO contracted printers to the test sites, OTSG and HCSCIA offices. Upon arrival it was discovered that the TDs and physician order sheets had been misprinted. Both TDs were printed in green color and the TD medication sheet (DA Form 4678-1 Test) was missing the slash through the "0" code. Physician order sheets were both printed in white.

Misprinted forms arrived within one month of the scheduled training period for all test sites. Following discussions, project officers and investigators decided to proceed with implementation plans in spite of the errors. Project officers felt the errors could be dealt with during training while awaiting corrected copies. It was the consensus that site staffs were ready to begin the study, all logistics had been managed well, and that further delay would prompt disinterest. Study investigators believed that reprinted forms would arrive during the test period, and as such it was decided that local staff members could be told of the errors during training.

Local nursing staffs used creative means of providing quick identification of the different misprinted forms. In most instances, the titles of the TDs were highlighted in yellow to distinguish one from the other. Although the doctor's order sheets were separated by chart dividers which identified the medication from nonmedication order sections, confusion reigned during the first several weeks of implementation. Color coding of medication and nonmedication order sheets and TDs had been planned to preclude exactly the confusion the misprinting had created, yet, there were no unusual occurrences generated as a result of the printing errors.

Reprinting of forms was completed following extensive coordination between investigators, the OTSG Nursing Consultant and DA forms and publications personnel. The reprint and distribution process consumed five months, with forms arriving at the end of the study period, rather than beginning, leading to another problem experienced by all sites during implementation: a lack of forms.

2) Form Supply. During the Planning Phase, test site personnel had been asked to estimate monthly form usage. The estimate included the number of patient discharges (to calculate the quantity of discharge summaries); and numbers of overprints used by the facilities (since many of those overprints would be using the revised TD and order sheets). The investigators increased all estimates by ten percent; yet, form estimates were approximately 40% less than actually used during the test period. The underestimation was believed related to the misprinting, an increased use of forms for training, and an increased "throw away" factor as staff members began to experiment with overprinting the new forms with approved material.

Because of their construction, some forms, i.e., DA Forms 3888-2, -3, -4 (Test), could be locally reproduced. FAMC was the only facility with the capability and moneys to reproduce the TD folders as levels became low. Emergency supplies were shipped between facilities to "get by" until reordered shipments arrived.

3) Overprints. As previously stated, local facilities had modified the 1977 forms through the use of overprinted material. The approved overprints were authorized for use on the test forms. Difficulties were encountered with overprinting the material onto the TDs, order sheets and discharge summary because of their structure. This became one of the more significant problems during testing and was overcome by several innovative methods at each site.

Because of its on-site printing capability, FAMC was the only facility able to reconfigure printing equipment to allow hand-feeding of order sheets and TDs which produced the required overprinted material. While waiting for overprinted documents to be produced from modified printing equipment, several computerized typewriters were used to generate overprinted documents. However, the first dilemma faced by forms management personnel at this facility was the volume of requested overprinted material. Once the "presses" were rolling, stock levels were maintained to preclude similar problems at FAMC.

The three other test sites, smaller in size than FAMC, and tenant facilities on their respective military posts, did not have the capability to reconfigure their own printing equipment, and were dependent upon support from the post-wide printing service to assist in addressing the overprint issue. None of the printing machines available at the test sites or in respective local communities had the capability of overprinting forms in either a bifold design (as the TDs were configured) or heavier weight paper. The three sites accomplished the overprint tasks through the use of local word-processing equipment, which allowed forms to be hand-fed into a computer (a labor-intensive, time consuming feat), or through the use of rubber stamps to imprint necessary material directly onto the form at the unit level.

Overprinting of the multiple-copy forms (doctor's orders and discharge summary) was also handled most often by word processing equipment at Forts Campbell and Polk. Because of limited word processing capabilities, personnel at Ft Jackson chose to copy the front page of an overprinted doctor's order sheet, type on that single sheet any standing orders and then reproduce those orders as single sheets. Pharmacy personnel were given copies of the standing orders to maintain on file.

Eventually, all sites were able to come to terms with the overprint issues. However, this was perceived by all site personnel as a major stumbling-block to implementation. The eventual resolution and positive outcomes were often displaced by the initial frustration felt by care providers as they attempted to test the forms.

4) Yellow Highlighter use. A yellow highlighter had been authorized for use in easily identifying discontinued orders on the 1977 forms. The study group had been advised by medical records personnel at the Headquarters, Health Services Command, that serious consideration was being given to discontinuing use of the highlighter because of reports of misuse, specifically use of a darker highlighting colors when the light yellow was not obtainable. This often led to obliteration of the orders on the TD sheets. Thinking that highlighter use was "on the way out", the study group decided to test highlighter discontinuation. A mechanism was devised to indicate discontinued orders by penning a line through the remaining dates appearing on the pertinent TD sheet. This mechanism was fully explained, with pictured example, in the test form guidelines.

The inability to use the highlighter to discontinue orders was cited by personnel at all facilities as another significant problem because of the ease with which such orders could be identified. In spite of the fact that another process was in place to discontinue an order, during a busy shift, such lines drawn by a pen could be overlooked by nursing personnel and current orders could be easily missed when buried among discontinued orders. Test site personnel attempted to overcome this problem by skipping additional lines between orders on the TDs or drawing heavier lines to denote discontinued orders. However, once it became apparent that the entire highlighter issue was not going to be discontinued at the headquarters level, the principal investigator made the decision to allow sites to resume the use of the highlighter, and thus, ignore one element of the test form guidelines. This completely resolved this issue among site personnel.

5) Questions Regarding Form Use. Guidelines for the use of each test form and the integrated progress notes were distributed to all test sites and incorporated into implementation teaching. A programmed text was also provided for site personnel to familiarize them with form structure and use changes. However, questions regarding form use and documentation changes continually arose during testing periods. Project officers at each site were advised to ask themselves two initial questions whenever issues were raised by personnel: "What do the guidelines say about the issue?"; and, "If not covered in the guidelines, what was the process in place prior to the test period?" For example, if questions were raised about the frequency with which narrative notations were required to be made in progress notes, the investigators referred inquiries to the guidelines. However, if a question was asked such as: "Where are forms filed in the medical record?" the response by investigators was apt to be "What did you do before the test period? How were forms filed then?" Once site personnel became more comfortable with the test forms and familiar with guidelines, most questions were easily resolved. The general "rule of thumb" became "business as usual if not specifically addressed in the guidelines."

7. PHASE IV.

a. Methodology. Significant activities in this phase included site debriefing of project officers (POCs), JCAH and IG surveys of patient records, and personnel surveys regarding documentation changes.

1) Project Officer Debriefing. In May, 1986, following the use of test forms at each site for approximately five to six months, project officers reconvened at Fort Sam Houston, Texas. Two POCs were scheduled for reassignment prior to distribution of participant questionnaires in July, 1986. Although each POC would submit a written summary of activities at their facility, their perceptions of the implementation phase and its intricacies were critical. Prior to arrival, officers had independently requested staff input regarding each form, the guidelines, programmed text.

During the two day session, each form was discussed in detail, suggestions for revisions were noted and accompanying guideline directives were also reviewed for appropriate changes. Additionally, officers and investigators discussed recommendations for worldwide implementation of forms and regulation changes.

2) JCAH and IG Surveys. Medical records at three test sites were reviewed by nurse surveyors of the HSC IG team during regularly scheduled

inspections. One site was surveyed by the JCAH nurse representative during a regularly scheduled tri-annual facility survey. IG members had served on the study working group and were thus familiar with test forms and guidelines. The principal investigator met with the JCAH nurse surveyor prior to the survey to describe the study and review the forms and guidelines which would appear in the patient records.

IG surveyors used documentation requirements as specified in the AMEDD Standards of Nursing Practice, AR 40-407, and the JCAH Standards for Nursing Services as criteria for record review. JCAH surveys are completed against their specific criteria.

All surveyors conducted retrospective and concurrent reviews of sampled patient records. Surveys were conducted in the usual manner used by each survey team for all facilities, hence there was no reason to believe methods at these four facilities differed from methods employed when reviewing patient records at other AMEDD facilities.

3) Personnel Surveys.

a) Study Population. During Phase II, working group members identified the need to formally survey site personnel regarding their perceptions of the documentation changes. The interest in the study issues prompted the decision to afford all personnel having experience with the tested elements on inpatient units the opportunity to participate. Health care providers having no exposure to test forms, e.g., those in ambulatory care environments, were excluded. No attempt was made to contact personnel outside the system on extended leave, TDY, etc. The study population included nursing personnel (civilian and military Registered Nurses [RN] and paraprofessional personnel), nursing unit clerks (ward secretaries), and other professional staff (Medical [MC], Dental [DC], Medical Service [MS], and Army Medical Specialist Corps [SP] officers and their civilian counterparts, and Physician's Assistants [PA]).

b) Instrument. Study-specific questionnaires were constructed for each of the four subject groups: Registered Nurse (Appendix H-2), Paraprofessional (Appendix H-14), Unit Clerk (Appendix H-25), and Other Professional Staff (Appendix H-32). During questionnaire development input was received from members of the working group, study director and project officers to identify specific points for query.

The questionnaires contained multiple sections with common questions repeated on each questionnaire. Those questions relevant (applicable) to only one specific group were excluded from other group questionnaires. For example, the writing of nursing orders on the nursing care plan and use of nursing diagnoses are specific to the RN function. Questions in this domain appeared only on the RN questionnaire.

Sections on the RN, paraprofessional, and unit clerk questionnaires dealt with comparing the "old system of documentation" with tested elements: each tested form and the integrated progress note. "Other professional staff" (OPS) questionnaires included segments regarding their use of nursing documentation forms for learning about nursing activities and patient condition, the physician's order sheet, and integrated progress notes. Professional data and open-ended response segments completed all surveys.

Subjects were asked to respond to most questions by circling a number which corresponded to a four element Likert scale: "Strongly Agree;" "Agree;" "Disagree;" "Strongly Disagree." A neutral response, such as "No opinion," was not included, thus forcing participants to make a selection signifying specific opinions.

Questionnaires were accompanied by an introductory letter signed by either the principal investigator of the study or Commander, HCSCIA. For coding purposes, case numbers were stamped on each booklet to identify facility, type of provider, and case.

Prior to distribution, the questionnaires were independently assessed for content validity, clarity, and appropriateness of questions by working group members, project officers, the study director, and ANC officers at Brooke Army Medical Center, Fort Sam Houston, Texas. Because these officers had had prior experience with test forms, either through initial development, field-testing, or implementation it was felt they could validly test the instrument. The reviewers believed the instruments to be comprehensive, inclusive, and valid vis-a-vis study objectives.

c) Procedure. Project officers identified the numbers of staff at their respective sites who would be available during the last two weeks of July, 1986, to complete questionnaires. Serially numbered questionnaires were placed in envelopes with corresponding numbers. The first digit of the case number signified questionnaire type; the second digit identified test site, followed by a three digit case number. Cartons containing the questionnaires and envelopes, with the four types separated by rubber-band, were shipped to project officers on 16 July 1986. Additional questionnaire copies were provided in case of misplaced questionnaires, or if the original subject estimate was low.

Directions (Appendix H-40) were mailed to each project officer to facilitate establishing a distribution and retrieval system. Project officers were authorized an assistant as necessary, but retained ultimate responsibility for the operation. Participants were assured of confidentiality and informed that data would be reported in an aggregate manner. Subject's consent to participate was implied by completion of the questionnaire. Individuals choosing not to participate were requested to return questionnaires to project officers in sealed envelopes. In that manner, regardless of retrieval system, the project officer would not know who had or had not chosen to complete questionnaires.

Project officers returned collected and extra questionnaires to the study activity by 1 August 1986. Those questionnaires not initially returned were separately mailed during August.

d) Data Analysis. Subject's responses were keyed directly from questionnaire to tape with 100% verification. Statistical analyses were performed using the Statistical Package for the Social Sciences (SPSS-X, 1986). Frequency distributions were computed for all variables. Crosstabulations were conducted between various sub-groups on select variables within each category of item. Content analysis was completed by the investigators on all open ended question responses.

b. Findings.

1) Project Officer Debriefing. All project officers (POCs) attended the debriefing, and brought comments solicited from personnel at their facilities. Their summaries of project implementation, including site specific comments regarding all tested elements, are contained in Appendix G. Because of the open discussion format of the two day meeting, the findings reported below are taken from notes recorded by project investigators, and POC summaries. Quoted remarks are representative of group consensus in each cited area.

a) Nursing History and Assessment Forms. Project officers agreed that their personnel "liked" the revised formats, and suggested the following changes when the form was revised:

- elimination of the "yes/no" column, thus providing a comment space for patient response;

- combining questions 7 (What other concerns do you have?) and 8 (How can we be most helpful?) into a Miscellaneous Information block which could be used to identify other concerns the patient may have with hospitalization;

- addition of the words "Date/Time" in the upper left hand corner of the assessment data area;

- elimination of the block reading "Typed or Printed Name of RN," thus allowing only for the signature of the RN to appear at the end of the assessment;

POCs also agreed that DA Form 3888-3 (the continuation form), although infrequently used on some units, seemed to be used by others (particularly if lengthy assessments and inter-unit transfers were common) with regularity. They further agreed that, because of unit specific needs, the form should be kept in the inventory.

b) Nursing Care Plan. Group agreement was unanimous in the following areas:

- this frequently used form, needed to be printed on more sturdy paper, with reinforced holes, to prevent ripping;

- the space for discharge considerations, which are started at the time of admission, should be moved to the front side of this form, thus reminding nursing personnel of their importance;

One site's POC brought the suggestion that a statement: "Care plan reviewed with patient," be printed on the form, accompanied by a block for the patient's initials. Following discussion, it was decided that such a comment would be left to the individual nursing unit's discretion for overprint at the local level. POCs were divided on the issue of whether or not to leave the nursing diagnoses on the reverse side of the form; while all agreeing they personally found them helpful, only two POCs felt they had enough support from their site personnel to warrant recommending that the diagnoses continue to be overprinted on this form. All agreed to await data from participant surveys.

c) Nursing Discharge Summary. Project officers agreed that this was a very popular form; nursing personnel were interested in having it maintained, in some fashion, following study completion. POCs further agreed that the form design was very busy; the numerous lines decreased clarity and frequently took up space which could be used for other discharge instruction segments. They recommended that redesign include the elimination of lines within major sections, and simplification of the "Follow Up" section to allow for specific data as required for discharge. The medication and treatment blocks were often found by site personnel to require additional space, although project officers agreed that such comments really depended on the specialty of the nursing unit. For example, patients on medicine units frequently were discharged with numerous medications, while those on surgical specialty units were often required to perform treatments at home. Group members decided that it would be impossible to satisfy all such unique issues. The carbon quality of the copies had also proven to be poor, prompting suggestions that the second copy be designated for the patient. Additionally, everyone also agreed that the ideal, a multidisciplinary discharge note, should eventually be developed.

d) Doctor's Order Sheets. All agreed that the separation of medication and nonmedication orders onto two different sheets had created significant problems for both nursing and physician staff, among which was an adversarial relationship between physician and nurse as each grappled with remembering which form should be used for what type of orders. Project officers noted they repeatedly heard physicians remark that they felt "nursing was making us do this," while frequent comments among nursing personnel expressed a dislike at being the "traffic cop" and "fighting" with the physicians over which form was to be used. As reported in Phase III findings, this problem was compounded by initial printing errors (incorrect color coding). From POC comments, it appeared as if such tensions and difficulties remained throughout the entire utilization period. POCs also reported that nursing staffs were increasingly made to flip back and forth among orders to double check for missed orders. While all project officers felt their nursing personnel and many physicians agreed that separating orders had its merits, if continued, it had to be done on one sheet of paper. Design concerns were also expressed by the POCs:

- physicians complained that there was not enough room for writing orders;

- line spacing did not conform to standard typewriter spacing, and thus made overprinting orders using a form fed machine very difficult and time consuming;

- the reinforced sheet top could not be fed through an automatic copy feeder to facilitate overprinting, further requiring a time consuming "hand feed;"

- the third copy of the sheet (buff colored, specified for nursing use) was usually of such poor quality it was not utilized by nursing personnel; nursing staffs also indicated infrequent use of this copy even when legible.

- the order sheet numbers were not sequential with their corresponding therapeutic documentation care plans, and thus,

would be filed separately in the patient record, causing further difficulty tracking orders and nursing actions.

e) Therapeutic Documentation Care Plans. All agreed on several points:

- the yellow highlighter must be used for noted discontinued orders. A mere line through such orders could often be missed, setting up potential action errors.

- the card stock paper, although much more sturdy than the "old" forms, caused problems which seemed to have a cascading effect: the inherent bulkiness added to the thickness of the record; frequently caused patient identification stamps to be blurred; made overprinting very difficult; and created significant storage problems for forms room and unit level personnel.

- the bi-fold design, while also having the advantage of increasing the amount of room for documentation, also had its disadvantages: three sites could not have the forms overprinted by an automatic feed copy machine; only FAMC, which owned more sophisticated equipment, eventually overcame this problem.

Although the card stock paper was thought to have disadvantages, all POCs felt their staffs favored the sturdier paper, despite the added cumbersome nature. POCs also agreed that as much as site staffs seemed to favor the advantages of the bifold design, unless the overprinting issues could be solved, these forms would have to revert to single sheet paper if implemented on a world-wide scale. Overprinting was such a critical issue that the practicality of daily use would be significantly hampered by the folder design.

If however, a solution was found to overprinting, and the bi-fold design maintained, POCs agreed on the following design changes:

- the patient identification block should be printed on all sides of the folder;

- recurring orders should all be contained on both sides of the inner portions of the folder (pages 2 and 3), with single actions on the front (page 1), and the less used "PRN" orders on the reverse side (page 4).

- codes should be placed on three of the four pages (only on one page of the recurring orders);

- a "year" block should be placed on each page (thus eliminating each time an order is transcribed);

- page one should have a section which notes the number of such forms in use for current hospitalization, e.g., "Form ____ of ____;"

- the terms "clerk/nurse" in the block for transcribing official's initials should be changed to "transcriber/ reviewer;"

- the paper stock should be changed to one less thick than card stock, but yet sturdy enough to withstand the constant handling such forms experienced.

f) Integrated Progress Notes. Project officers reported that their nursing staffs were divided on this issue; many wanted to return to the separate nursing note, others to continue using progress notes. The POCs also identified that other health care providers were equally divided. One point seemed clear at all facilities: the TDs were not being utilized as originally designed, which created problems with narrative charting. On one hand, at the time of the debrief, POCs reported that nursing personnel had yet to fully utilize the TDs to subsume much of the routine daily nursing activities and patient responses. There were several reasons, foremost of which was the overprint difficulty. Consequently, narrative notations in the progress notes were not succinct, nor truly reflective of the patient's progress. On the other, it became evident, that nursing personnel were frequently not documenting on either the TDs or the progress note, and valuable nursing data was being lost. Additionally, POCs reported that many nursing personnel had not yet reached a "comfort" level with themselves and their documentation, which allowed them to look positively on their written notes. POCs also identified that all levels of nursing personnel required some additional element of training to keep notes brief and clear.

Finally, POCs agreed that the few months of testing were not enough to change, what for some health care providers, was a career lifetime of separated narrative notations. Yet, each POC acknowledged, that each day brought improvements. After lengthy discussions, as with other issues which divided opinions, POCs agreed to await study survey results.

g) Practicality for Daily Use. By all POC accounts, initial weeks of implementation were hampered because of the significant problems created with printing errors. However, once appropriate forms had arrived, resolution of overprint problems had begun, and personnel became more familiar with the tested elements, POCs acknowledged that the study course ran more smoothly. Adjustments by staff members were necessary. Several clinical areas had reported logistical difficulties with the forms. For example, Intensive Care Unit staff's usually kept specialty flowsheets, plus the TDs and nursing notes on a clipboard at the patient's bedside. The bi-fold design of the TDs made use of the clipboards very cumbersome. It seemed to be more work, rather than less, for these specialty areas to document. Specific difficulties were overcome by the ICU staffs in different ways: some chose to continue to use the specialty flow sheet, placing the TDs with the patient record; others obtained boards with spiral loops rather than clips, which allowed the TDs to be closed and flipped over with relative ease. Other areas chose to place the progress notes with the flowsheets on the clip boards to help care providers find data more easily. Nursing personnel on many units had to become accustomed to not having the freedom of keeping their narrative notations separate from the patient record. Progress notes kept with the inpatient chart forced nursing personnel to readjust documentation habits. For example, rather than waiting until the end of a shift to document, they would frequently make chronological entries at the time of occurrence, in order to preclude the

traditional "end of shift" rush for the patient record. Orientation and inservice training were recurring requirements. Because the tested elements were a change for everyone, and used at only these four sites, any new employee, either military or civilian, had to be oriented to the study, the forms, and guidelines. Few military personnel had been reassigned between the test units. Regardless of experiences at other Army medical treatment facilities, incoming personnel who had any interface with inpatient documentation required training. Because of its numbers of personnel and frequent turnover, particularly during the summer rotation months, FAMC personnel eventually developed a video tape to be used for orientation; the other sites incorporated training within Department of Nursing programs, or oriented physicians as the need arose.

Despite inherent difficulties associated with any change on this scale, POCs reported that, as with the integrated progress notes, each day seemed to bring improvement, and staffs felt that, except for the separated physician orders, the benefits of the tested elements would outweigh the difficulties. POCs agreed that the more formal survey to be conducted during the summer months was critical.

h) World-wide Implementation. Following lengthy discussion, project officers agreed on two key points. First, it was crucial that world-wide implementation be approached in an organized fashion with implementation directions coordinated at the OTSG level. Secondly, POCs recommended that form and guideline implementation follow the manner in which the test was carried out. In essence, world-wide implementation would consist of four elements: preimplementation coordination of logistics by a central activity; use of training teams to educate local facility personnel; local training and decisions about phase-in of new forms; follow-up activities and clarification of questions. The central activity (OTSG level) would assist in coordinating printing and shipping requirements; preparation of regulations governing documentation principles and form use; preparation of necessary training aides; coordination with other disciplines at the OTSG levels. Because of the magnitude of the training efforts, POCs recommended that a regional approach to training be taken: regional coordinators and teams appointed who would be trained, and then be expected to "train the trainers" at the local facilities. POCs also suggested that test site personnel would be valuable resources to assist with such training efforts. POCs also suggested that training and implementation be coordinated around a conference attended by most Chief Nurses and/or Chiefs, Nursing Education and Staff Development Offices, so training logistics would be disseminated to facility leaders who would eventually appoint local coordinators and training team members.

The training issues were of paramount importance from the POCs' perspective. They agreed that, had they the option to "do things differently" each would have programmed more time for training. Group sessions would have been used more frequently at all sites, with an emphasis on the change in use of the TD forms: using the TDs to document the results of activities, not merely as annotation of performance of a task.

Regional activities had to include appointment of a regional coordinator who could function as the regional resource for questions and answers and also serve as conduit for issues between the local facility and central coordinator. POCs believed that the "train the trainer" concept could be more fully utilized if begun at the regional level. POCs felt it important that local facilities

have some structure for implementation requirements, but also enough flexibility within the structure to meet local needs. For example, the central activity might decide a specific target date for full world-wide implementation, while facilities could choose the dates and manner in which phase-in activities would be approached. Local facilities would receive training aides from the central activity, but could also develop facility-specific programs to introduce the forms and new guidelines.

Finally, POCs unanimously supported the frequent use of electronic mail between all levels of activity to quickly share "lessons learned," capitalize on achievements, and to stay abreast of necessary changes. They also suggested that facilities undergoing accreditation surveys during, or shortly following, implementation, be closely monitored to further facilitate problem solving and information sharing.

The project officers recognized that all their world-wide implementation recommendations were lengthy, and could prove to be costly if regional meetings were required. However, they also concluded that the favorable results of careful planning would result in: fewer problems than they had faced with test-site implementation; emphasis on the positive elements of the new forms and revised regulations; and facilitation of the arduous change process for each facility.

2) JCAH and IG Survey Results.

a) JCAH Survey Results. While the JCAH survey encompassed retrospective record review, it also focused on concurrent review of inpatient records containing the test forms. Hence, the overall commendable rating received by one facility was also reflective of test form use. Specific comments were made by the surveyor regarding several tested elements:

- thoroughness of discharge summaries found on the test form (DA Form 3888-5, Test) in comparison to those summaries written previously in nursing notes;

- integration of progress notes provided less fragmenting of overall information; particularly noteworthy were records reviewed from intensive care areas; and

- the use of codes and writing of patient responses on the therapeutic documentation care plans provided further continuity to care documentation.

b) IG Survey Results. All findings reported by the IG surveyors were in Category II. In general, for all facilities, while nursing histories and assessments received praise for those records completed during test form use, issues surrounding identification and prioritizing of nursing care problems and related nursing interventions were noted for all facilities. (Because of the confidentiality of IG survey reports, individual test sites are identified only by number in the following paragraphs.)

(1) Site 1. On the surface, Site 1 appeared to fare well during two surveys. In the survey preceding the test form period, while there were several findings regarding the inpatient treatment record, there were no recorded deficiencies related to the nursing process. One commendation was

made regarding medical record documentation of minimal care patients noting that review revealed ongoing assessment of patient needs by the physician and nursing staff. Much effort had gone into developing hospital policy and procedures to ensure rapid identification of changes in the condition of these patients.

The IG survey during the test form period made no mention at all of nursing process documentation. However, the nurse surveyor later indicated to the CNR investigator that she had been about to render a Category I finding due to an almost total lack of nursing documentation regarding patient progress based upon her retrospective chart reviews until she met with the Chief Nurse to discuss the situation. Site 1 had been using test elements for approximately four months when the survey was conducted. All charts retrospectively reviewed had been those completed in the first month of test form use. The Chief Nurse had identified the problem the month prior to the survey: while assessments and care plans appeared adequate, he stated in a memorandum to all nursing personnel: "...most records I reviewed revealed inadequate documentation of nursing interventions...it was difficult to determine the patient's status from the nursing progress notes." The nursing staff was instructed that until such time as the clinical head nurses and supervisors determined that nursing documentation on the progress notes and therapeutic documentation care plans reflected care provided, the frequency with which nursing progress notes were to be recorded was, at a minimum, to be based upon the acuity of the patient.

(2) Site 2. Site 2's documentation was highly commended following the preceding year's IG survey which cited several documentation deficiencies including the lack of nursing care problems based on the assessment, and further, lack of nursing orders developed for problems which had been identified. The site's admission assessments were cited in the 1986 survey report as "generally comprehensive and timely" during test form use. Retrospective and concurrent chart reviews of records using tested elements further identified a great improvement over the prior year's findings: nursing care plans (NCPs) were relevant and well developed with nursing orders for all problems identified on the NCP. The commendable finding cited the emphasis placed on the importance of documenting all elements of the nursing process by personnel in the Chief Nurse's Office and the Department of Nursing Quality Assurance coordinator.

(3) Site 3. Site 3 had documentation findings for succeeding years, including the test site year. Discussion of findings included incomplete documentation of the nursing process specifying the same issues regarding a lack of care problem identification and corresponding nursing orders for existing problems. Site 3 had a noted improvement in the timely completion and content of nursing assessments. Preceding survey results noted that assessments were not always clearly identified as having been completed by an RN, and, in some instances, were incomplete.

However, Site 3's participation in the CNR study and its documentation deficits were specifically mentioned in one of the survey result comments: "The need to identify and plan for essential elements of care was even more imperative in this MEDDAC since participation in the nursing documentation study allowed for decreased frequency of charting. The writing of pertinent nursing orders based on problems identified during assessment was essential in order to facilitate the documentation of care provided and evaluation of the

patient's response to these nursing interventions by the abbreviated methods allowed in using the test forms in the study."

(4) Summary Comments from IG Surveyors. In a memorandum for record to the CNR investigators the IG surveyors:

- conveyed their belief that eventually tested documentation changes would make an impact on the quality of the medical record.

- identified that further education was needed emphasizing the writing and structuring of nursing orders to facilitate documentation of patient response on the TDs, much like an "activities of daily care flowsheet."

- noted that the problems cited from all three facilities in the area of problem and nursing order identification wee not ones which would be solved by the piece of paper on to which words were written. Such issues would be resolved only through the cognitive process and dedication given to them by the RN on the nursing unit.

- based on their collective seven years experience of record surveys, attested to the fact that such problems existed at all medical treatment facilities.

3) Personnel Surveys (Appendix I). A total adjusted population of 1151 subjects was identified. Final returns yielded 1077 (94%) responses; 231 (20%) of these questionnaires were unusable (returned blank or incomplete), for a usable questionnaire rate of 74% (N=849). Survey subjects were distributed in the following manner: 37.4% (n=316) Registered Nurses; 31.4% (n=266) nursing paraprofessional personnel; 4.1% (n=35) Unit Clerks; and 27.1% (n=229) other professional staff (Appendix I, Table 1). A breakdown of the "other professional staff" (Appendix I, Table 113) revealed that the vast majority (n=186; 84.2%) were physicians.

a) Written Comments. Content analysis was conducted on the more than 1100 written responses (Appendix I, Table 101). More than half of all comments focused on the physician order sheets (34.1%), integrated progress notes (16.4%), and therapeutic documentation care plans (13.8%). All tested elements solicited some form of written comments from survey participants. The content analysis is further described below in segments addressing each tested element. The reader is advised that quoted responses are perceived to reflect individual comments pertaining to a specific section and are not to be construed to reflect the majority opinion. Each quoted comment is preceded by a notation identifying authorship: "RN" (Registered Nurse); "P" (Nursing Paraprofessional); "D" (Physician); "UC" (Unit Clerk).

b) Comparison of 1977 Forms with Test Forms. Several questions in all surveys dealt with the comparison of the 1977 forms to the tested forms. Nursing personnel were asked to respond to perceived use with questions like: "Compared to the old system, I feel the test forms save nursing documentation time;" and "Compared to the old system, I feel the test forms improve communications about the patient between nursing and other health care professionals" (Appendix I, Tables 3-13). Other professional staff personnel had been asked how the tested elements assisted them in learning about nursing activities and the patient's condition (Appendix I, Tables 39-54).

Nursing personnel, in general, agreed that the tested elements:

- saved nursing documentation time (Appendix I, Table 3);
- decreased redundancy of documentation (Appendix I, Table 4);
- encouraged RNs to use the nursing process (Appendix I, Table 7);
- were easier to use (Appendix I, Table 8);
- improved communications concerning the patient among nursing personnel (Appendix I, Table 5);
- improved communications concerning the patient between nursing and other health care providers (Appendix I, Table 6);
- provided a better picture of patient progress (Appendix I, Table 11);
- improved the quality of documentation on their specific units (Appendix I, Table 13); and
- were a "definite improvement" (Appendix I, Table 10).

With the exception of the integrated progress notes, test forms and guidelines did not seem to have changed the other professional staff members' use of nursing information to learn about nursing activities and the patient's condition. For example, when queried about the frequency with which the following nursing forms had been used, the minority responded with "For Every Patient" or "For Most Patients:"

FORMS	PRIOR TEST	DURING TEST
Nursing History and Assessment	28.4%	34.4%
Nursing Care Plan	8.7%	11.3%
Nursing Discharge Summary	7.7%	10.6%
Nonmedication TD	30.4%	40.9%
Medication TD	41.6%	42.3%

However, the use of progress notes and narrative nursing notes provided a different view. Prior to the test, 52.4% of the "other professional staff" respondents indicated that they used the nursing notes either "for every patient" or "for most patients" to learn about nursing activities and the patients condition (Appendix I, Table 53). During the test period (when nursing notes were integrated with all other providers' progress notes), more than 73.3% responded that they had used the progress notes to learn about nursing activities and patient condition "for every patient" or "most patients" (Appendix I, Table 45). Sixty-nine written responses addressed the overall system changes, providing both positive (51) and negative (18) comments. The

positive comments were often brief and succinct: (RN) "Overall Good;" or (RN) "A good system. Needs some modifications, but let's keep it." Other positive comments were more reflective:

> (RN) "If used properly, the 'old' forms enhanced commo (sic) among nursing personnel. The change in forms may improve commo (sic) if the nursing process and planning care is better understood. All in all, test forms are excellent upgrade from previous ones and have good ideas. They make implementing the nursing process easier, although it could have been done with the 'old' ones if desired."

Most of the positive comments were from registered nurses, although one physician wrote:

> "I really don't feel I'm qualified to answer...when I arrived here the new documentation was in effect and I haven't any idea of the comparison. I will say it's much easier than documentation in any of the civilian hospitals where I've worked before coming here. I find the documentation more concise and complete than any other I've ever done."

On the opposite side, were those who felt that the changes had primarily increased "paper shuffling," and "caused documentation to consume more time than patient care."

c) Satisfaction with Documentation Changes.

(1) Integrated Progress Notes. The majority of "other professional staff", RN and paraprofessional nursing personnel tended to agree with the statements that the integrated notes:

- lessened fragmentation in the chart (Appendix I, Table 87);
- improved communication between all groups (Appendix I, Table 84);
- made it "easier" to determine the patient's condition (Appendix I, Table 90); and
- should be available for use at all Army MTFs (Appendix I, Table 93).

Sixty-four percent of the "other professional staff" respondents acknowledged that the integrated notes had encouraged them to read narrative nursing notes more than in the past (Appendix I, Table 89); 91% of all nursing personnel agreed that the integration encouraged them to read other care providers' notes more than when the notes had been separated in different areas of the medical record (Appendix I, Table 92). In addition nursing personnel felt that an integrated concept encouraged more thorough, but concise, documentation (Appendix I, Tables 85, 86).

"Other professional staff" respondents identified that they had little difficulty identifying nursing notations (Appendix I, Table 95), authors of previous notations (Appendix I, Table 94), or locating their own previous narrative notations (Appendix I, Table 96). These had been reasons most cited by staff members prior to testing for not using an integrated concept for

progress notes. On the other hand, this group of respondents did not agree that the integrated notes lessened the amount they had to document (Appendix I, Table 88).

Written comments again reflected both positive and negative aspects encountered by users during the testing period. The number of these comments was second only to those made regarding physician order sheets. The positive comments focused on the general satisfaction with all providers using the same narrative forms, the perceived improvement in communication, and the desire to maintain the concept of integrated notes after the testing period.

> (RN) "Best idea of all!"
>
> (RN) "Once I got use to charting on the progress sheet I liked it."
>
> (RN) "Definite improvement. Learn alot (sic) more about the patient's status. Encourages reading of other's notes."
>
> (RN) "Love it. It makes me think more and improve quality of individual notes. The physicians had a fit about it initially. They are beginning to come around and accept it. Sometimes they actually read our notes! This was, in my opinion, the biggest and most important change that should be implemented worldwide. It was a giant leap forward in the continuing saga demonstrating that we are professionals."
>
> (P) "Helpful for displaying total picture of patient's status."
>
> (P) "Recommend keeping nurses notes combined with physicians."
>
> (RN) "We must keep this part."
>
> (D) "I have always relied heavily on TPR graphic sheets and nursing medication 'white sheets' as well as nursing notes. In the past, nursing notes were not as readily available as they are now. I feel the current placement of nursing notes in the 'progress notes' is a clear improvement because they are always readily available and contain important information in the overall care of the patient."
>
> (D) "Integrated progress notes are an improvement because they are on the same chart and therefore easier to review."

Negative comments were grouped in several areas: paraprofessional entry, decreased documentation and lack of nursing notations; physician dissatisfaction; sequencing; increased fragmentation and difficulty locating information; notation quality and duplication; and those which advocated returning to separated notations. Comments regarding paraprofessional entry were related to the substance of a notation which were linked to both the clinical and writing skills of the paraprofessional:

> (D) "Consolidated forms allowed for ridiculous nursing notation by paraprofessionals: 'agree with previous assessment' with signature to follow notations from consultant staff, staff and house staff involving aspects of patient care they were

untrained to evaluate. But because they 'wrote a note' they were free of the obligations to document nursing observations and patient assessments from their areas of concern and training."

(RN) "Paraprofessionals should be allowed to write on progress notes, but there were problems with the 'old' form in getting some individuals to chart appropriately. Should they be practicing on the SF 509?"

(RN) "Need to increase paraprofessional proficiency in charting."

(D) "Many of the nurse's aides, etc., make notations in the record...which show lack of technical observational skills. Having their notes in the progress notes makes it difficult to follow the true progress of the patient. They are certainly not of sufficient quality to be countersigned and decrease the charting time for health care professionals."

Others described what they felt to be a noticeable lack of nursing notations, and decreased documentation:

(RN) "The simplicity of the system has resulted in less charting, but until all the documentation habits have changed, there will be a decided lack of appropriate nursing entries."

(RN) "This decreases services responsibility, especially physician and nursing, to chart. Even though something is charted, my legal responsibility to document has not been released."

(RN) "We have found that some physicians are not documenting on notes for days at a time, simply because the nursing staff is."

(D) "Nurses make less notes with integrated progress notes. I miss their daily notes."

(D) "My biggest problem is lack of nursing notes. This is especially true of 1) PRN orders (which are) difficult to determine when, why and result of use; 2) patient's emotional status was totally lacking in current notes; 3) patients seem to have more unresolved, undocumented, minor complaints at the time of discharge than with previous notes..."

(P) "Need more usage by nursing staff -- too little charting being done by nurses."

Nursing personnel were concerned that physicians did not read their notes; and both nursing and physician personnel addressed concerns regarding notations out of sequence, which frequently wrought more confusion and made information harder to find:

(RN) "I found the decreased requirements to chart has caused some fragmenting of the records. It is difficult to decide where to look for the information."

(RN) "Notes are always out of sequence since physicians just start new pages for their notes rather than sift through nursing entries. I think they (MDs) read nursing entries more when they were separated from doctor's progress notes."

(D) "Far too little care is taken by nursing staff to write note in an orderly, consecutive or chronologic fashion. More attention should be taken to this problem..."

(D) "Nurses' notes in doctors' progress notes makes for confusion and difficulty finding critical information. Both should be kept separate."

(D) "The integrated progress note is nearly impossible to read. I find myself reading nursing notes LESS (writer's emphasis) often due to frustration at trying to locate other MD progress notes or consultation notes."

Comments were made by both nursing and physicians regarding quality and duplication of notations:

(RN) "ICU mandates we record all assessment notes during each shift even if the MDs have the same findings."

(D) "Most nursing notes are too long and filled with non-essential, cover your position, repetitive shift-to-shift verbiage. Put this stuff elsewhere. Keep progress notes concise and meaningful and they'll be read and contribute to overall communication and care."

(P) "Daily nurses notes on all patients is presently required. Frequently nothing new needs to be charted and an entry is a waste of time."

(D) "Information...is often duplicated."

Finally, there were comments from each group suggesting return to separated notations:

(RN) "The fact that we document most things on the TDs causes the doctors some difficulty, as they cannot always follow our TDs...In all honesty, I miss the nurse's notes as I feel we perceive things differently than the physician."

(D) "Leave the progress notes to the physicians!"

(P) "Separate doctor notes and nurses notes."

(2) Separated Orders. Nursing personnel and "other professional staff" respondents differed in their opinion of the separation of medication from nonmedication orders. The RNs, paraprofessional and unit clerk personnel were more in favor of the separation (Appendix I, Table 56), identified having "minimal difficulties" with the separation (Appendix I, Table 55) and agreed that orders should remain separated on color-coded sheets

(Appendix I, Table 56). The majority (53.4%) of the OPS respondents (Appendix I, Table 55) identified that separate order sheets caused more than minimal difficulty and were almost evenly divided regarding separating medication from nonmedication orders: 49% agreed that orders should remain separated; 51% disagreed (Appendix I, Table 56).

Written comments were divided along the same lines. Positive comments from nursing personnel highlighted their appreciation for the single action order column which eliminated the necessity of recopying certain orders: (RN) "I did like being able to sign off stat or one time orders that were done and didn't have to be transcribed." Positive physician comments focused on the ease of referencing medication from nonmedication orders:

> (D) "Separate order sheets for medications make it much easier to review previously ordered meds (sic) at a glance in conjunction with the medication 'white sheet.'"
>
> (D) "I routinely separated my orders for medications prior to the institution of these forms. I do not 'mind' using the new format, but it has not been of additional help for my patients. It has helped when seeing patients followed by another doctor to quickly check current medications."

Not only did the physician order forms elicit the largest percentage of written comments, but the majority were negative in nature. Physicians and nurses commented about the increased "paperwork," confusion and time of use.

> (RN) "...Not having to transcribe saved time, but trying to figure out if something was done often took more time."
>
> (RN) "It's too time consuming to check two copies of orders each time the chart is flagged. Also, MDs write on wrong forms and we have to track them down."
>
> (D) "Two order sheets increases my workload and the nurses inform me that the orders do not significantly decrease their workload."
>
> (D) "In the course of writing orders for a patient with multiple medical problems, it is very easy to lose the train of thought when having to switch back and forth between order sheets."
>
> (D) "The key to proper order identification is a legibly written, complete order; separation on separate forms increases paperwork without resolving the underlying issue."

There was also concern on the part of both types of care providers about missed orders:

> (RN) "Too many orders were missed with the separate order sheets."
>
> (RN) " The separation of medication and nonmedication orders seems to serve no purpose other than to aggravate doctors and make it easier for nursing staff to overlook one or the other set of orders."

(D) "I found repeated examples where ward clerks and nurses would take off orders on only one set of sheets despite flagging both sets."

(D) "It is very confusing to try to separate medication from nonmedication orders when writing orders on rounds, admissions and postops (sic). They have led to many accidental order deletions on my part."

(D) "'Split' orders continue to be confusing and have on at least two occasions, resulted in 'missed orders.' I obviously don't like them, but would happily accept if clearly, in nurses' (users') opinion, (they were) a significant help to them."

Nurses, unit clerks and physicians expressed preference for one sheet:

(RN) "I feel more comfortable with one order sheet. I do like the single order sign off section."

(UC) "One sheet is sufficient..."

(D) "If it truly makes the nurses lives easier and decreases paperwork, one can adapt to the change, i.e., it's easier now than it was when first instituted. But if to deal with it doesn't really help the nurses, it would be much better to revert to one order sheet."

Several redesign comments were also made, primarily focusing on maintaining separation of types of orders, but confining them to one sheet:

(RN) "It would be helpful if the medication and nonmedication MD order sheet were back as one. A possibility would be to put a dotted way over on the page and start all med (sic) orders there. That way they are still easily identified."

(RN) "People have suggested med & nonmeds (sic) be written on the same sheet, only side by side, in 2 separate columns, as opposed to separate sheets."

(D) "In my medical school training, we always wrote medication orders in a different area than nonmedication. However, our order form had the following: a 2 sided format which allowed the doctor to write both orders without constantly flipping pages. This is much faster and more efficient!"

(3) Nursing History and Assessment Form. There was agreement among nursing personnel that the reduced number and content of questions were sufficient (Appendix I, Tables 14, 15) and that the personal articles block appearing on the front side of the form was "helpful" (Appendix I, Table 16). Nursing respondents also identified that the bulk of nursing histories were being taken by non-RN/ANC nursing personnel (Appendix I, Table 17). In compliance with Army regulations and the study guidelines, assessments were being performed by a Registered Nurse (Appendix I, Table 18). RNs were in favor of having the assessment categories, as appeared in DA Pam 40-5,

overprinted on the form (Appendix I, Table 23) since they were not only helpful (Appendix I, Table 21), but were perceived to increase the use of the categories (Appendix I, Table 22). The majority of nursing personnel (54.2%) identified that the nursing history and assessment continuation form was not frequently used on their unit (Appendix I, Table 20).

Written comments primarily focused on redesign, but included a few positive and negative replies. Positive written comments included phrases such as: (RN) "Better than the old way;" (RN) "Assessment categories are very helpful;" and (P) "Clear and concise on gathering pertinent information." Personnel remarked that they found the continuation sheet: (RN) "Useful for transfers to/from the unit;" and (RN) "Helpful for recording admission criteria." Negative comments expressed the view that fewer history questions did not necessarily add to the quality of the nursing history: (RN) "I like the old form with more nursing history questions. Some of the old questions needed deletion, but now too brief (sic);" and, (RN) "The old form, though (sic) it took longer to complete, gave us a better overall history of the patient." Revision comments included suggestions to add material, e.g., space for listing medications and health problems; space for patient's and local contact's address; area to note habits such as smoking and alcohol consumption, space to document patient teaching, and family history. Deletions were also suggested, e.g., personal items inventory, assessment categories, question "How can we be most helpful."

(4) Nursing Care Plan. Overprinting of nursing diagnostic categories on this form was viewed in a favorable light by the RNs: 88.5% agreed that such an overprint was "helpful" (Appendix I, Table 25); 84.5% agreed that it increased their use of the nursing diagnoses (Appendix I, Table 26); and 90.9% agreed that the categories should continue to appear on the NCP (Appendix I, Table 27). Eighty-seven percent of the nursing paraprofessionals identified that they do use the care plan to learn of patient goals (Appendix I, Table 28).

Positive written comments included expressions such as: (RN) "Excellent;" and "Improvement, more room to write." Some RNs expressed a dislike of having the nursing diagnoses overprinted on the form: "It makes reading the page confusing and restricts my use of the form." However, as with the history and assessment forms, most comments suggested design changes:

> (RN) "Nursing discharge considerations should somehow be put on the front of the form so we would see them."
>
> (RN) "Put overprint of diagnoses on the front page."

(5) Nursing Discharge Summary. Again, a favorable view was taken by RN personnel regarding the creation and use of this form. Respondents:

- agreed that the summary contained elements necessary for a discharge note (Appendix I, Table 31);
- liked having the form serve the dual purpose of discharge note (Appendix I, Table 32) and patient information copy (Appendix I, Table 33);

- felt an outpatient record copy to be important (Appendix I, Table 34);

- would like to keep such a form (Appendix I, Table 35), but to have it be multidisciplinary in nature (Appendix I, Table 36).

Written comments also reflected favorable use of this form:

(RN) "Definitely needs to be kept since RNs give alot (sic) of discharge instructions. Made overprinted with specific instructions for my ward."

(RN) "Long overdue."

(RN) "Helpful in eliminating having to rewrite information."

The few negative comments often focused on the redundancy of information in all providers discharge notes, which gave support to comments advocating eventual multidisciplinary discharge note:

(RN) "Do we all have to write the same discharge note?"

(RN) "Feel this is unnecessary for this is all info (sic) on doctor's discharge summary sheet."

(RN) "Multidisciplinary form would be great if other disciplines would use."

Written comments also suggested redesign considerations:

(RN) "Delete the need for initials in each section. One line at the bottom with a space to sign off would suffice.

(RN) "Get rid of the lines. They drive me crazy. Would be much more helpful just to have blocks to write in."

(RN) "Need more room for meds (sic); less room for instruction."

(RN) "Section on appointments is confusing."

(RN) "...should have a place for diagnosis."

(6) Therapeutic Documentation Care Plans. Questions for nursing personnel were focused in the two areas of change with regards to these forms: the concept of recording patient responses directly on the TDs and the tested folder format. Personnel liked recording responses directly on the sheet containing the orders (Appendix I, Table 61). Furthermore, such a concept was felt by nursing to have:

- improved nursing documentation (Appendix I, Table 64), communication among nursing personnel (Appendix I, Table 66), and communication between nursing and other disciplines (Appendix I, Table 67);

- decreased fragmentation of information (Appendix I, Table 68); and

- provided a better "picture" of the patient (Appendix I, Table 70).

Personnel were of the opinion that such a concept should be available worldwide (Appendix I, Table 73). Paraprofessional personnel identified that because of this concept, the TDs had become their main source of documentation (Appendix I, Table 62).

The folder format was viewed as an improvement over the previous format (Appendix I, Table 74), with respondents agreeing that the PRN and single actions need to be kept separated (Appendix I, Table 78). The sturdier paper, even with numerous overprinting problems, was also viewed as an asset and should be continued (Appendix I, Table 77) even if orders cannot be easily overprinted (Appendix I, Table 75). However, the overwhelming majority of nursing personnel identified that the use of a yellow highlighter to discontinue orders was essential (Appendix I, Table 83).

The third largest group of written comments were made about the TDs. Positive and redesign comments were often intermingled:

> (RN) "It's great; need more staff members to be more consistent with the patient response codes."
>
> (P) "Easier to work with; improves charting and saves time."
>
> (UC) "Keep these forms."
>
> (RN) "Need to encourage use of codes. Should show patients ID (sic) on all sides."
>
> (RN and UC) "Would be better if PRN actions were placed on the back of the sheet and both inside sections used for recurring orders."
>
> (RN) "Must be able to be overprinted and remain color coded."
>
> (P) "More space needed in blocks."
>
> (P) "Need more room to write why a medication was given and its effectiveness."
>
> (RN) "Can these be revised somewhat so you aren't constantly flipping/flopping. Alot (sic) of people end up missing or forgetting to sign off treatments because they are impossible to keep in order."

Several comments were made about coding issues:

> (RN) "Coding should be the same on both forms. I like the idea of codes but would use different words than satisfactory or unsatisfactory. Maybe an additional few codes would be appropriate."
>
> (RN) "Find a more effective way to document response of patient other than a plus or minus."
>
> (RN) "Effectiveness codes are not utilized. Changing forms will not solve this problem, but this is a good form."

(RN) "I dislike using codes. Orders are not always effective or ineffective, e.g., patient states he got some relief from pain with this medication."

(P) "The forms are easier to use but do not allow for specific information to be obtained, such as how much of a diet was eaten...1/2, 1/4, 3/4, or all. The "yes" and "no" codes don't allow for deviations."

Not all study respondents were pleased with the new format, suggesting a return to previous ways, particularly the use of a single sheet:

(RN) "Integrate to one form. Does not work well for minimal orders, e.g., labor and delivery; too bulky.

(RN) "Bulky with too many folds and places to look for orders."

(RN) "The folder method proves confusing."

(RN) "Single sheet format."

(P) "Reinstate old forms."

Respondents making written comments regarding yellow highlighter use unanimously agreed that the highlighter must be used to discontinue orders. As one paraprofessional put it: "The blocking out with yellow marker was more alerting to the eye than the current (way) of discontinuing an order."

8. DISCUSSION

As noted at the beginning of this project report, forms and documentation are a necessary part of nursing's daily life. The investigators outlined but four stated overall objectives as the study process began. However, the true "bottom line" was the attempt to find a less cumbersome system, which would provide a mechanism for world-wide Army nursing personnel, regardless of specialty area, to appropriately, simply, promptly and accurately record essential elements of daily patient care, and any variations in the patient's response to the therapeutic regimens. Essentially, a single solution that would fit everything. In that vein, we went about trying to describe documentation's various perspectives.

Study questions which addressed all aspects of the tested process, from survey to implementation, have been answered. Yet, at the same time, the dilemma of documentation persists. When is enough, enough, or even too much? When is it too little? Perhaps the crux of this study was the ability to use three pieces of paper, on which the bulk of patient data could be recorded: the therapeutic documentation care plans, holding documentation of "normal" or "expected" responses to interventions; and the progress note sheet, onto which could be recorded the deviations from the care, summary statements of changes, or even agreement with a colleague's assessment.

Did it work? Yes, but... Integrated progress notes, with accompanying use of the TDs to subsume the bulk of the day to day "charting," began to allow

the exchange of ideas in one area of the patient record; consolidate information about the patient from the myriad of disciplines; provide a more chronological record of events from "start to finish." Yet, full success depended upon important changes: everyone's, not just nursing's, understanding of the new use for the TDs; thorough annotation of nursing orders to cover all care actions (e.g., writing a nursing order for "daily wound checks" which would facilitate recording of normal healing processes); appropriate, and frequent notation of responses on the TDs; and the ability to write a "quality progress note," that is, one which was succinct, showed technical observational skills, used appropriate medical terminology, etc.

Those changes, as reported, were not as successful as others. The linchpin may be time. The literature supports that the longer a process is in place, and the more radical the departure from the "norm," the more arduous and lengthy is the change. Although training was conducted prior to implementation of tested documentation forms and concepts, and personnel learned more with each passing day of the test, habits slowly changed. Yet, because of time constraints, surveys were conducted only four months into the project. This could explain what might, at first, seem to be a split vote on integrated notes. Respondent's written survey comments also leave one with the sense that during the test period, as habits changed, there were even "fewer" bits of nursing information. It is important to note that the overwhelming majority of all respondents (85.1%) and nearly 63% of nonnursing respondents were in favor of having integrated notes at all Army facilities. Although problems existed, respondents placed merit to the concept, and want to continue its use.

Comment must also be made on two diverse perspectives: that "more" is automatically "better;" or that "less" is preferred. Volume does not necessarily correlate with quality; in fact important measurements and observations may be obscured as they are buried in voluminous notes. However, regardless of the simplicity allowed by any system, until habits are changed, a dearth of appropriate notation may be the result. For example, simply agreeing with a previous assessment does not satisfy documentation requirements if the writer is untrained to evaluate the validity of the assessment, or is still adjusting to the expanded use of the TDs and chooses not to document in either progress note or TD area. Nursing observations and patient assessments are important. The perspective and content of such notations has changed drastically over past decades as education and technology improvements have increased nurses' and paraprofessionals' skills. Yet, when pressed for time, on a shift when chaos may reign, and priorities must be set, nursing personnel must remain diligent to safeguard appropriate, albeit, abbreviated documentation.

The separated physicians' orders was much too arduous a change, proving the most difficult to manage and causing repeated conflicts between providers. Printing errors further added to the confusion at implementation startup. The investigators pause to wonder the course of study results if this element had not been attempted. Would it have allowed nursing personnel to concentrate on learning and feeling comfortable with the expanded TD use? Would it have allowed physicians less of a point of focus on multiple changes, and increased acceptance of the integrated note concept? While there are no final answers to these questions, it would seem reasonable to conclude that one less change would not have had a negative effect.

With the exception of the separated physicians' order sheets, when all other study elements are taken into consideration, respondents expressed satisfaction with changes, citing the ease of use, improved communication, simplicity and flexibility of the new system. Easier transition to the less drastic changes such as the revised history and assessment form, and nursing care plan may play a part in the positive responses. Yet, again, innovation theory reflects that new habits are not substituted for old unless the users see utility to the change, and it shows a clear and unambiguous improvement over its antecedent.

Some might challenge that if the tested system were really that much more simple, it would not have taken extended training sessions, complicated logistics, and detailed guidelines to implement. The forms would have "spoken for themselves;" one look would have allowed users to immediately know for what purpose and how the form was to be used. The investigators agree. Had we simply tested a new history, assessment, care plan and discharge form such issues would be moot. The complexity arrived with expanded TD use, and became more so because of form construction (not to mention additional early printing errors). Early in form development, study group members had decided they did not want to relinquish the RN's ability to write nursing orders. At the same time, group members liked the idea of having a piece of paper on which multiple days of data could be recorded without necessitating recopying of orders. Had these not been important issues, it is envisioned that the group would have probably tested a form found in the civilian community: one generated daily; a flowsheet of sorts, which, allowed notations of standard activities of daily living, e.g., nutrition, activity level, vital signs, etc., for each shift. Such a form also allowed the user to then refer to a narrative note, found either on the reverse side of the same sheet or on an integrated progress note. The drawbacks were obvious: daily recopying of order levels; no addition of nurse driven orders. Certainly, it would be simpler, yet users would have to relinquish what are obviously preferred elements. There are tradeoffs to every new idea. The investigators still feel this flowsheet has merit for testing if users chose to relinquish a form with the noted characteristics.

The study process was lengthy; this report, too, has been lengthy. The investigators would be remiss, however, not to emphasize some relevant methodological and philosophical issues. Documentation, regardless of the system, is only as good as the person who puts pen to paper. As long as any system is still requiring manual labor in the form of writing, rather than an automative process allowing the user to select from a menu of responses, its quality will often elude objective measure, continue to be value laden and relative within the context of the reader's perspective. With apologies to a Supreme Court justice, the investigators would venture to write that some might even say "I can't define good documentation, but I sure know it when I see it." The reverse may be even more obvious: "I sure know what's missing when I don't see it." The search for quality then becomes more a hunt for the lack of, rather than the presence of, the written word about a patient's response to therapeutic regimens.

Automation will not be a panacea. It will still require the presence and active participation of a health care provider to put observations and conclusions to computer screen, or scroll through itemized lists. Yet it has the enormous potential to remove the drudgery behind the process, insure thoroughness of notations, and address that elusive quality issue head on.

Finally, as health care becomes more complex and costly, emphasis placed on shorter hospital stays, and the search begins in earnest for an element of managed care within the AMEDD system, coherent, concise, yet detailed notations will be the treasured norm. Whether the record is read by the physician, nurse, lawyer, or budget analyst, each will be searching for evidence of quality documentation which will help to explain events occurring during the course of hospitalization. AMEDD inpatient records must work for them, not visa versa. The investigators fervently hope this effort has headed in the former direction.

9. RECOMMENDATIONS

a. Based upon study findings, the following recommendations are made:

1) Medical Record - Nursing History and Assessment, DA Form 3888-2. Recommend implementation with minor design changes (Appendix N-2) on the front and reverse sides:

- Front: elimination of "Yes/No" column; elimination of questions 7 and 8 ("What other concerns do you have;" and "How can we be most helpful?") with remaining blank spaces to be used as local need dictates.

- Reverse: addition of the words "Date/Time" in the upper left hand corner of the assessment data area; elimination of the block reading "Typed or Printed Name of RN," thus allowing only for the Signature of the Registered Nurse to appear at the end of the assessment.

2) Medical Record - Nursing History and Assessment (continued), DA Form 3888-3 (Appendix N-4). Recommend implementation as tested (Appendix E-4). Allow the form's continued use to update admission assessments as necessary, for transfer assessments or for overprinting as local needs dictate.

3) Medical Record - Nursing Care Plan, DA Form 3888-4. Recommend implementation with the following design changes (Appendix N-6): moving the "Discharge Considerations" block from the reverse to front sides; extending the care plan grid on the reverse side of the form.

4) Medical Record - Nursing Discharge Summary, DA Form 3888-5. Recommend implementation with minor design changes (Appendix N-8): elimination of lines within major sections; simplification of "Follow-Up" section; designate copy #2 as "patient copy" and copy #3 for the health record/outpatient medical treatment record. It is further recommended that, at some point (either upon implementation if design issues can be resolved, or at a later date) the form become multi-discipline in nature allowing care providers other than the nurse, e.g., physician, dietitian, physical therapist, etc., to address discharge considerations within their own realms.

5) Clinical Record - Doctor's Orders, DA Forms 4256. Recommend one order sheet subdivided into two distinct sections: medication orders and non-medication orders (Appendix N-9). The following design changes are further recommended:

- the form would continue to be multiple copy, with tear pages sent to the pharmacy after each set of orders is written; new order sheets would be initiated once a page is filled with orders on one side or the other, or if all the copy pages have been sent to the pharmacy. In the latter situation, if orders do not fill the original page, but there are no additional copy pages, the remainder of the original page would be crossed out to eliminate the possibility of a written order without duplicate pharmacy page.

- space the order lines to allow for standard typewritten spacing;

- change top reinforcement to facilitate automatic feeding through a copy machine;

- eliminate the "buff copy".

6) Therapeutic Documentation Care Plans (Nonmedication) (Medication), DA Forms 4677-1 (Appendix N-10) and 4678-1 (Appendix N-16). Recommend exploring the overprint/folder format issue onto cardstock with other machinery; the ideal resolution would be to allow the folder format to remain as tested (Appendix E-11 and E-15), with the sturdy paper. If the folder can be maintained the following design changes are recommended:

- maintain the single action section on page one (folder front) with the recurring order sections on pages two and three (in the middle section of the folder); page four (the reverse side of page one) would be used for the "PRN" orders.

- place Patient Identification block on all pages;

- place the phrase "continue on reverse" on page 3, indicating a continued section on the fourth page;

- place related codes on three of the four pages (only on one page of the recurring orders);

- place the year block on each page;

- create a section on page one denoting the number of such forms in use for this hospitalization, e.g., "Form ___ of ___";

- change the terms "clerk/nurse" in the block for transcribing official's initials to "transcriber/reviewer";

- change the paper stock from card-stock to a less thick, but yet sturdy enough stock which could satisfactorily withstand the constant handling such forms will experience.

If the overprint/folder format issue cannot be resolved, the following are design recommendations:

- return to one piece of paper onto which overprints can be easily accomplished;

- have the "Single Action" and "PRN" sections appear in separate blocks on the front side of the form, along with appropriate patient identification, year, page number, and transcriber/ reviewer changes as previously suggested;

- print the "Recurring Orders" section on the reverse side of the form, along with the appropriate codes;

- reduce the recurring orders section to encompass completed actions for one week, rather than a longer period of time, in order to enlarge the blocks for coding.

Finally, regardless of design change, use of the yellow highlighter to denote a discontinued order must be reinstated.

b. Integrated Progress Notes. Recommend worldwide implementation of integrated progress notes in conjunction with authorizing use of codes on the therapeutic documentation care plans. Further recommend that all providers be required to identify their notes by discipline, e.g., "Nursing Note"; "Physical Therapy Note", "Attending Physician Note", etc., and that notes be not only dated, but also timed. The latter could be most easily accomplished with the addition of a date/time column on the progress note form (SF 509). Pages should be numbered; hence, it is recommended that future redesign of the SF 509 include a notation designating paging sequence, e.g., "Page ___ of ___." Recommend that referencing a nursing care plan problem number be optional for nursing notations.

c. AR 40-407, Nursing Records and Reports, Regulatory Changes. For the most part, if forms are implemented as previously recommended, the CNR Study Guidelines would provide the basis for any required regulatory changes. However, other specific recommendations are made based upon information obtained throughout the course of the study:

1) General Comments: General sequencing of information about the nursing process and forms' descriptions should be changed to provide a more logical flow, e.g., begin with the nursing process rather than a description of doctor's orders. Other general recommendations are:

- expand the brief mention of the nursing process, as it pertains to the documentation issues (AR 40-407, para 2-5), to describe the four phases of the process (Note: Appendix E-19, CNR Study Test Form Guidelines, para 2a-d).

- include a brief statement about the purposes of nursing documentation.

- decide on terms to describe various levels of nursing personnel. Do not interchange terms such as "Nurse," "RN," "professional nurse." The term "nurse" can be used to describe both registered and licensed practical nurses.

2) Nursing History and Assessment Forms. Recommend discussion of each form in separate sections within the same paragraph of the regulation. Further recommendations are that:

- the regulation be strengthened to encourage the performance of the history and assessment at admission by allowing the admission assessment note to suffice for a duplicate note in the progress notes. If an assessment is not completed at the time of admission, the regulation should then require some type of admission nursing progress notation.

- the assessment be completed within any period specified by JCAH standards.

- the regulation specify, as does DA Pam 40-5, that " . . . the nursing history is obtained by the nursing personnel . . . the nursing assessment is completed and recorded by an RN;"

- a statement be inserted into the regulation which parallels one in DA Pam 40-5 related to the extent of the required nursing assessment: "data on the biophysical status . . . as appropriate for planning care . . ." (p. 2-1);

- a statement of accountability similar to the one contained in the CNR Guidelines, pg. 10, item (3).

3) Nursing Care Plan.

- Discussion of nursing care plan development should be separate from the discussion related to the nursing history/assessment forms.

- Include the use of both therapeutic documentation care plans in any discussion on nursing orders or the use of such forms as they relate to actions taken to solve problems specified on the care plan.

- Define "nursing orders"; strengthen to provide as much "clout" as orders written by a physician.

- Incorporate "Nursing Diagnosis;" allow its use in lieu of patient problems.

- Address isolated instances when there may be no problems to be noted on admission (e.g., item e., page 15, CNR Guidelines).

- Address short term admission requirements; if a "local policy" is to be the answer for these admissions, such should be clearly stated in the regulation.

4) Patient Discharge Plan. Recommend completion of this form at discharge suffice for discharge nursing progress note.

5) Doctor's Orders. Description of this form should follow the nursing history, assessment and care plan forms. It then leads into the therapeutic documentation care plan forms. Mandate the use of prescriber's stamp to follow signatures on order sheets to preclude illegible signatures.

6) Therapeutic Documentation Care Plans. Although these are complementary forms, they should be described in separate paragraphs, even if similar information is repeated in both paragraphs.

7) Nursing Progress Notes. Recommend regulatory changes as used throughout CNR study and specified in the CNR Study Guidelines. The only addition to the guidelines would be to authorize local decisions affecting the frequency of narrative notations if a monitoring process at the facility were to disclose inadequate documentation on either the progress notes or the therapeutic documentation care plans.

d. Worldwide Implementation Recommendations fall into four basic rubrics: preimplementation coordination of logistics by a central activity; use of a regional concept to "train the trainers" who will eventually train selected teams from local facilities (all using the same training aides and regulatory guidelines); local training and decisions about phase-in of new forms; and any necessary follow up activities and issue clarification.

1) Preimplementation Coordination: Central Activities. Worldwide implementation activities should parallel those which occurred in preparation for the test period. Because of the magnitude of the implementation, central coordination is recommended to accomplish necessary logistics for local facility activity.

- Recommend central coordination be accomplished at the level of the OTSG Nursing Consultant;

- Requirements at this level will include:

  * form volume estimates and coordination of printing process through OTSG and DA publications directorates;

  * preparation of regulatory guidelines governing form use;

  * preparation of training aides for implementation (video tapes, programmed text, information papers, form packets, slides and overhead transparencies, etc.)

  * coordination of regional training officers and teams;

  * coordination of regional team training.

  * coordination with other disciplines, particularly patient administrators and medical records specialists. Recommend dissemination of form information, implementation plans and schedules in major command newsletters with appropriate sections.

- Recommend regional coordinators and teams as follows: the eight HSC regions; 18th Medical Command; 7th Medical Command. Also recommend a representative from the Nursing

Science Division, Academy of Health Sciences, Fort Sam Houston, TX, to provide instruction for the ANC Officer Basic Course students.

- Recommend use of as many personnel with test site experience as possible, particularly as regional coordinators or team members.

- Recommend training commence while forms are printed and stocked at depots, thus allowing preparatory time for necessary regional coordinator/teams training and subsequent regional training for local facility coordinator and team members.

- Recommend training and implementation be planned as close to a conference for chief nurses as possible so training logistics are disseminated to facility leaders who will eventually appoint local coordinators/team members.

2) Preimplementation Regional Activities.

- Regional coordinators and team members: identified by regional chief nurses; should be well versed in documentation issues, have good oral communication skills, be comfortable with presenting material to large audiences, and be accessible to local coordinators and team members; either military or civilian registered nurses (note above recommendation for use of personnel with test site experience).

- Requirements at this level will include:

  * attendance at central training sessions;

  * organization of regional training sessions for local coordinator/team members;

  * serving as resource personnel for questions/issues arising during local facility implementation; conduit for such questions and issues to central coordinator.

3) Preimplementation Local Facility Activities.

- Local Facility Coordinator/Team Members. Appointed by facility Chief Nurse; recommend similar characteristics as regional members; recommend facility coordinator who is an ANC or civilian RN with access to all areas of the hospital's operations, having good rapport with all disciplines and who is not likely to be reassigned on a permanent change of station during the implementation course. The most likely candidates for such a coordinator role include section supervisors, nursing education/staff development or quality assurance personnel and nurse methods analysts. Team members can likely include a non-commissioned officer practical nurse (91C military

occupational skill) with characteristics similar to those described for regional members.

- Requirements at this level will include those similar to test site project officer coordination and planning activities. All planning should be coordinated through necessary local approval channels.

  * Attendance at regional training meeting.

  * Coordination of time table for local training and phase-in of new forms and regulations.

  * Conduct of necessary local training classes to introduce form and regulatory changes. Recommend particular emphasis on the writing of nursing orders in a manner which facilitates use of the codes on the therapeutic documentation care plans; and narrative nursing progress notes reflecting the condition of the patient in a succinct manner. Recommend training to include all disciplines, particularly physicians, because of the change in use of order sheets, progress notes and therapeutic documentation care plans. Patient Administration personnel, particularly the chief and medical records personnel be fully briefed on the forms and regulatory guidance. Recommend reference to project office reports for local implementation strategies pertinent to facility size.

  * Consult with regional coordinators/team members to solve facility issues/problems and answer questions.

  * Provide progress reports to regional coordinators using mechanisms established within the region.

4) Implementation Activities. Recommend overall time table be established by the central coordinator for the implementation process. Thus, world-wide facilities would have some flexibility with local implementation plans, while ensuring an implementation end date. Further recommendations include:

- communication of regional and local implementation time tables to central coordinator using mechanism established by the central coordinator.

- close monitoring of those facilities which undergo any scheduled inspections during or shortly after implementation. Positive comments should be passed along to all facilities via the electronic mail system to aide with implementation; problem issues must be solved with resolutions shared with all facilities.

- maximum use of electronic mailing systems to quickly communicate information to all facilities following implementation.

10. REFERENCES

Barbiasz, J.E., Hunt, V., Lowenstein, A. (1981). Nursing documentation: A format not a form. Journal of Nursing Administration, 11(6), 22-26.

Barnett, H.G., (1953). Innovation: The basis of cultural change. New York: McGraw-Hill Book Company, Inc.

Costello, S. & Summers, B.Y. (1985). Documenting patient care: Getting it all together. Nursing Management, 16(6), 31-34.

Creighton, H. (1980) Nurses charting: the supervisor nurse. Journal of Leadership and Management, 11, 42-43.

Department of the Army. (November, 1981). Army Medical Department Standards of Nursing Practice.

Huckaby, L.M.D. & Neal, M.C. (1979). The nursing care plan problem. Journal of Nursing Administration, 9(12), 36-42.

Joint Commission on Accreditation of Hospitals. (1986). Accreditation Manual for Hospitals. Chicago, IL: Author.

Kushner, G. (1962). What Accounts for Sociocultural Change? A propositional Inventory. Chapel Hill: Institute for Research in Social Science, University of North Carolina.

Lundsgaarde., H.P., Fischer, P.J., Steele, D.J. (1981). Human problems in computerized medicine. Lawrence, Kansas: University of Kansas, Publications in Anthropology, Number 13.

McClosky, J.C. (1980). Nurses' orders: the next professional breakthrough. RN, 43, 99-113.

Neiderbaumer, L. (1984). Documentation on the Patient's Chart: Workbook. Chicago, IL: Author.

Nightengale, F. (1957) Notes on Nursing: Replica, 1859 Edition. facsimile ed. Philadelphia, Toronto: J.B. Lippincott Company.

Nursing records and reports, Army Regulation 40-407. (1985) Washington, D.C.: Headquarters, Department of the Army.

Weeks, L.C. & Darrah, P. (1985). The documentation dilemma: A practical solution. Journal of Nursing Administration, 15(11), 22-27.

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APPENDICES

APPENDIX A

Current DA Forms

MEDICAL RECORD – NURSING ASSESSMENT AND CARE PLAN

For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.

DEMOGRAPHIC DATA

1. LOCAL ADDRESS	2. LOCAL TELEPHONE	3. LANGUAGE
	4. RELIGION	5. OCCUPATION

ADMISSION DATA

6. DATE	7. TIME	8. NEXT OF KIN
9. REASON FOR ADMISSION	10. INFORMANT	

NURSING HISTORY	YES	NO	INSTRUCTIONS: USE PATIENT'S OWN WORDS WHEN POSSIBLE. USE ITEM NUMBER FOR EACH RESPONSE.
11. What has the doctor told you about your illness?			
12. What plans does the doctor have for you?			
13. Have you been hospitalized before? If YES, describe most recent hospitalization.			
14. Do you have any other health problems? If YES, explain.			
15. Did you take any medications or treatments before your admission? If YES, name, frequency, reason, last time taken, meds brought to hospital.			
16. Do you have any allergies or sensitivities? If YES, explain and describe reaction.			
17. What is your usual eating pattern? Number of meals? Snacks? Diet restrictions?			
18. Do you have any trouble sleeping? If YES, explain. Aids used?			

PATIENT'S IDENTIFICATION	REGISTER NO.	WARD NO

NURSING HISTORY *(Continued)*	YES	NO
19. Do you have any problems with your bowels (diarrhea, constipation, or other)? Aids used? If YES, explain.		
20. Do you have any problems with urinating (frequency, burning, urgency or other)? If YES, explain.		
21. Do you need help with eating, bathing, dressing, or walking? If YES, explain.		
22. Do you have any difficulty with seeing, hearing, speaking? Any special aids used (glasses, hearing aid, crutches, cane, other)? If YES, explain.		
23. Do you have any particular likes and/or dislikes we should know about to provide care for you or any religious or cultural practices you would like us to respect? If YES, explain.		
24. Do you smoke? If YES, type and amount?		
25. Do you drink alcoholic beverages? If YES, amount and frequency?		
26. What do you normally do for hobbies, recreation, etc?		
27. How do you usually handle and react to situations which upset you?		
28. Do you have any special concerns or requests that will help us to make your hospital stay easier? If YES, explain.		
29. Who do you have to assist you when you are discharged?		

SIGNATURE *(Nurse)*	DATE

MEDICAL RECORD – NURSING ASSESSMENT AND CARE PLAN (Continuation)

For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.

ADDITIONAL ASSESSMENT DATA

SIGNATURE *(Nurse)*	DATE

PATIENT IDENTIFICATION

(CONTINUE ON REVERSE)

INSTRUCTIONS: Number and initial each recording and indicate Long(L) and Short(S) term goals.

DATE IDENTIFIED	PROBLEMS	EXPECTED OUTCOMES *(Goals)*	L/S	DATE ACCOMPLISHED

DISCHARGE CONSIDERATIONS:

Patient-Family Teaching:

Special Considerations: *(Sociopsychological needs, Limitations, Disabilities, etc.)*

Other:

Post Hospital Disposition:

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-400; the proponent agency is the Office of The Surgeon General.

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION
↓
DATE OF ORDER
TIME OF ORDER ________ HOURS
LIST TIME ORDER NOTED AND SIGN

NURSING UNIT
ROOM NO.
BED NO.

PATIENT IDENTIFICATION
DATE OF ORDER
TIME OF ORDER ________ HOURS

NURSING UNIT
ROOM NO.
BED NO.

PATIENT IDENTIFICATION
DATE OF ORDER
TIME OF ORDER ________ HOURS

NURSING UNIT
ROOM NO.
BED NO.

PATIENT IDENTIFICATION
DATE OF ORDER
TIME OF ORDER ________ HOURS

NURSING UNIT
ROOM NO.
BED NO.

A-6

DA FORM 1 APR 79 4256

REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*

For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.

Mo. ____ Yr. ____

VERIFY BY INITIALING | *INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION*

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS; FREQUENCY, TIME	HR	DATE COMPLETED														

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

D 8 9 10 11 12 13 14 15

E 16 17 18 19 20 21 22 23

N 24 01 02 03 04 05 06 07

DA FORM 1 OCT 78 4677 — EDITION OF 1 DEC 77 MAY BE USED.

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)					Mo _____ Yr _____
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials	

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED													

☆U. S. GPO: 1981—341-646/8261

CLINICAL RECORD — THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)

For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.

Mo.____ Yr.__

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:

ADDITIONAL PAGES IN USE ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

DISPENSING TIMES

USE PENCIL, CIRCLE MED TIMES

D 7 8 9 10 11 12 13 14

E 15 16 17 18 19 20 21 22

N 23 24 01 02 03 04 05 06

DA FORM 1 FEB 79 4678

EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED.

Verify by Initialing

THERAPEUTIC DOCUMENTATION CARE PLAN
(MEDICATIONS)

Mo. _____ Yr. _____

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED													

U.S. GPO: 1982-0-394-028/1000

MEDICAL RECORD – SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-400; the proponent agency is the Office of The Surgeon General.

REPORT TITLE	OTSG APPROVED *(Date)*

(Continue on reverse)

PREPARED BY *(Signature & Title)*	DEPARTMENT/SERVICE/CLINIC	DATE

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)*

- ☐ HISTORY/PHYSICAL
- ☐ FLOW CHART
- ☐ OTHER EXAMINATION OR EVALUATION
- ☐ OTHER *(Specify)*
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

A-11

MEDICAL RECORD	PROGRESS NOTES

DATE	

(Continue on reverse side)

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility)*	REGISTER NO.	WARD NO

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
Prescribed by GSA/ICMR,
FPMR (41 CFR) 101-11 806-8
509-110

PROGRESS NOTES

DATE	

CLINICAL RECORD	NURSING NOTES *(Sign all notes)*

DATE	HOUR		OBSERVATIONS
	A.M.	P M	Include medication and treatment when indicated

Continue on reverse side

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first middle; grade; date, hospital or medical facility)*	REGISTER NO	WARD NO

NURSING NOTES
Standard Form 510
General Services Administration and
Interagency Committee on Medical Records
FPMR 101–11.806–8—October 1975
510–109

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated

GPO : 1983 O - 414-397

APPENDIX B

Methodology Phase I

DEPARTMENT OF THE ARMY
OFFICE OF THE SURGEON GENERAL
WASHINGTON, D.C. 20310

REPLY TO
ATTENTION OF:

DASG-CN

18 NOV 1983

SUBJECT: "Field Test Clinical Nursing Records Study"

Chief Nurse
Office of the Surgeon
US Army Training &
Doctrine Command
Ft Monroe, VA 23651

1. In recent years, much controversy has surfaced regarding all nursing documentation. General dissatisfaction has been verbalized within the Corps. In addition, numerous requests for exception to policy and requests for overprints have punctuated this concern. Consequently, the AMEDD Study Program for FY 84 (IAW AR 5-5) tasked the Health Care Studies and Clinical Investigation Activity (HCSCIA), Fort Sam Houston, Texas, to examine the entire inpatient nursing documentation process.

2. The study will investigate possible changes to meet ANC and JCAH standards in the most logical, expeditious and efficient manner. All nursing documentation in the fixed facilities along with the appropriate Army Regulations will be reviewed. Nothing is sacrosanct. Proposed changes will be field tested at several sites prior to recommendation for full AMEDD implementation.

3. You and your staff (ANC Officers, enlisted personnel, and civilian employees) are requested to provide the principal investigators with comments regarding problem areas and suggestions for change. Many of our professionals have interacted with the civilian sector. Can we draw from their experience? What is working elsewhere? This is your opportunity for input.

4. Lastly, would you be interested in having your facility used as a test site for the proposed, innovative documentation study? We are interested in several sites of varying size. The sites will be determined early in calendar year 1984 and decisions communicated to selected Chief Nurses by the Study Director in the HSC Nursing Division.

5. Your suggestions and preference regarding use as a test site should be submitted NLT 13 January 1984 to:

Commander
HCSCIA
ATTN: HSHN-H (MAJ Martha R. Bell)
Fort Sam Houston, TX 78234
AUTOVON 471-4541/5671

DASC-CN
SUBJECT: "Field Test Clinical Nursing Records Study"

Negative replies are requested.

6. I am proud to serve with members of an articulate, experienced and educated Corps. Our documentation should reflect the quality of care we know is rendered to our clients. Your assistance in this high priority matter is appreciated.

Connie L. Slewitzke

CONNIE L. SLEWITZKE
Brigadier General, ANC
Chief, Army Nurse Corps

APPENDIX C

Findings Phase I

Summary Sheets

AR 40-407 SUMMARY SHEET

There is a concern about the numerous policies and regulations governing nursing documentation. Several suggestions discussed the need for concise documentation reference which is incorporated with other AMEDD regs on documentation. Sample comments include:

> "There is a strong need for a concise and complete nursing documentation reference. AR 40-407 as a single reference is neither specific nor as comprehensive as is needed. Participants identified the programmed instructional material used in the ANC basic course as a document applicable for use in all inpatient care facilities." HEIDELBERG
>
> "AMEDD should have regulations on the required documentation rather than separate regs for each branch. Collaboration will become more of a reality in this instance...(there) should be one or a short series of regulations that cover all inpatient patient care records in a coherent manner instead of the current mismash of disjointed regulations." DIX
>
> "Use of forms is more of a problem than the forms themselves. The charting system and supporting policies must be clearly and consistently transmitted to users..." FORT CAMPBELL

Most of the suggestions for specific changes to AR40-407 were made as if there would be no alteration of present forms. It will be essential for the study's efforts to recommend AR revisions if any of the current forms are altered. The revision recommendations will require a paragraph by paragraph review. The following is a summary of paragraph change suggestions received from the field.

> Chapter 1-3.C. "Change to: each registered nurse is responsible for the accuracy and completeness of his/her entries, as made in clinical records, and for ensuring compliance with all doctors' orders. No one registered nurse, ANC or civilian, is 'more' licensed' to practice than any other one. Each professional should take responsibility for their own actions and the actions of assigned personnel at the time that the RN or ANC is in charge of the ward, unit or health activity. This responsibility does not belong to the Head Nurse alone. The Head Nurse facilitates the accuracy and completeness of records by assigned personnel, but should not accept the responsibility for the same, especially when it involves other personnel." KOREA
>
> Chapter 2-4.D. "Change to: List the time each order is noted and initial. Signature verification (Medical Record-Supplemental Medical Data DA Form 4700) is included in each patient's chart to use as reference for initials..." KOREA
>
> Chapter 2-6.B. "...Elimination or abbreviation for admission assessment/care plan for short stay patients (less than 72 hours) ..." BAMC "...If anyone other than a professional nurse completes the DA 3888 or the front of the DA 3888-1, the form should be countersigned by a professional nurse. The signature would indicate the form had been reviewed for content and accuracy. The counter-signature should be required prior to the paraprofessional leaving at the end of the shift. ..." WBAMC (PI note: according to JCAH requirements the assessments are

to be done by the Professional Nurse, not merely checked for accuracy if performed by one other than the RN).

Chapter 2-7.C.8. "...The AR requires that when orders are recopied they must include the doctor's name. However, there is no requirement to copy the physician's name when the order is originally transcribed. No one is writing the physician's name with either the original order or the recopied order..." WBAMC

Chapter 2-8.C. "...On admission note on SF 510: There is repetition on this note that is also found on the top of the DA 3888. All information should be entered on one form..." KOREA "These admission note requirements duplicate information already contained on the DA 3888 and on many of the approved DA 3888-1 overprints containing additional assessment data, i.e., allergies, already noted in the DA 3888, DA 4677 and DA 4678! Can't admission nursing notes be written on either DA 3888-1 or the SF 510 per local policy?..." WBAMC (PI note: this seems to be saying that the regulations need to specify somewhere that information contained in one portion of the chart, e.g., nursing notes, need not be repeated in nursing documentation or visa versa).

Chapter 2-8.E. "Medications: Only STAT medications (indications and effectiveness) should be annotated on the SF 510. Time and type of medication is already recorded on the DA 4678 for PRN medications and this information does not need to be repeated on the SF 510. Indication (type and location of pain, or other symptoms requiring PRN medication) for PRN medications should continue to be recorded on the SF 510. Effectiveness of PRN medications should be somewhat incorporated onto the DA 4678 and annotated under the time, date, and initial block by one word, e.g., 'yes' or 'no', or perhaps the symbol '+' or '-'. These short words or symbols would indicate whether or not the RPN medication ordered was effective, then these observations need to be annotated on the SF 510 with the plan of action to remedy the problem. 'Routine' post-operative pain medications (as an example), if effective, should not have to be recorded on the SF 510 each time given if they are effective..." KOREA "Terminal cancer" patients require regularly scheduled narcotic medications Q 2 hrs for pain control.

(NOT PRN). Is it necessary for every single dose to be charted on the SF 510? The medication is being signed off on the medication sheet for each dose given..." WBAMC

"...Need an abbreviated format to expedite effectiveness of PRN medications (form could have a legend: E = Effective, I = Ineffective and only those drugs ineffective or given for the first time would be annotated in SF 510..." BAMC

Chapter 2-9. "...Recommend developing a standardized Nursing form to be given to the patient at discharge (original copy to stay in Chart). Currently each institution is "Recreating" the wheel in developing such an overprint on the DA 4700..." WBAMC

Finally, during the previous efforts to confront the documentation problem, a new AR was drafted by the 1982 task force. A copy is included for reference (Encl 1).

DISPOSITION FORM

For use of this form, see AR 340-15; the proponent agency is TAGO.

REFERENCE OR OFFICE SYMBOL	SUBJECT
DASG-PSC-N	AR 40-407, Chapter 2 Revision

TO: Clinical Nursing Records Ad Hoc Committee Members

FROM: DASG-PSC-N

DATE: 19 Apr 82 sls/78394

CMT:

1. Inclosed is the revision of Chapter 2, AR 40-407 as recommended at the committee mee 28 September 1981.

2. Revision of Chapter 2, AR 40-407 will be used in support of the DA test of revised forms DA 4678 (SG Form 7 - Test); DA 4677 (SG Form 8 - Test) and documentation of the nursing history and nursing assessment on either SF 509 or SF 510.

3. Subject revision will be used as guidance in the TOF form test where determined ap- Propriate.

4. Please comment and return to this office NLT 18 June 1982.

Darlene K. McLeod

1 Incl
as

DARLENE K. McLEOD
Colonel, ANC
Nursing Consultant

HSXM-DON (19 Apr 82)

TO Nursing Consultant
ATTN: COL McLeod

FROM LTC Mary J. Wise

DATE 5 May 82

CMT 2

Per our conversation, this is written well.

MARY J. WISE
LTC, ANC
Committee Member

Incl 1

CHAPTER 2

PERMANENT CLINICAL FORMS

2.1 General. Initiation of a permanent clinical record is an essential part of the inpatient admission procedure. A permanent outpatient treatment record is maintained on each outpatient seen in an Army medical treatment facility (AR 40-66). Authorized clinical records forms which nursing personnel are responsible for or use frequently are described in this chapter.

2-2. Recording data. All entries will be made with a pen, using reproducible black or blue-black ink, except when specifically stated otherwise.

2-3. Correcting errors. Erasures are prohibited. A line will be drawn through an incorrect entry, and the initials of the person making the entry will be placed above the lined-out portion. The correct information or statement will be recorded following the lined-out entry.

2-4. Clinical Record-Doctors Order (DA Form 4256).

a. Disposition and use. DA Form 4256 is a three-part carbonless form maintained in the patient's chart. The original copy of the form (white copy) remains with the permanent record. The second copy (pink) is sent to the pharmacy. The Pharmacy receives a copy of all orders to ensure proper surveillance of food-drug and laboratory-drug interactions. The pharmacy copy is retained until the patient is discharged. The ward copy (yellow) is used to communicate all orders to the nursing staff. It may be used as a medication treatment reminder and will be discarded when no longer required. All entries will be made with ball-point pen, using blue-black or black ink. Entries must be legible on all three copies.

b. Preparation. Enter all patient identification as directed in paragraphs 3-9 and 3-10, AR 40-2. Addressograph plates should be used in each part marked "patient identification." The nursing unit, room number, and bed numbers must be completed.

c. Method of writing orders. The prescriber will record the date time and the order is written as indicated on the form. One or more orders may appear in each part of the form, but no more than one order may appear on a single line. Each order must be accounted for separately Use of the entry "Routine Orders" (to imply a number of predetermined orders) is prohibited. A group of orders written at one time for the same patient requires only one signature and one date entry per sheet (DA Form 4256). Standard orders which are overprinted on the form must be signed by the prescriber. When additional sheets are required for continuation of a group of orders written at one time, each sheet will reflect both a date entry and a signature.

d. Method of accounting for orders. Written orders will be accounted for in the extreme right column titled "List Time Order Noted and Sign." The clerk (or nurse) who noted two or more orders may enclose the orders in a brace, list the time those orders are noted and sign his or her name. All 'stat' orders, however, must be individually accounted for by listing the time the order is

noted and signing his or her name. These notations imply that proper action has been taken and the order has been transcribed to DA Form 4677 (Therapeutic Documentation Care Plan (Non-Medications (SG Form 8-Test) and/or DA Form 4678 (Therapeutic Documentation Care Plan (Medication) (SG Form 7-Test).

e. Method of discontinuing orders. To discontinue a medication or treatment, a stop order must be written and signed by the prescriber. Automatic stop orders (e.g., antibiotics, controlled drugs) will be governed by local written policy. When an order is stopped, it is noted (as described in d above). It must then be transcribed to the corresponding order in the Therapeutic Documentation Care Plan, using the notation "DC/date/initials." A single line must be drawn through the grid adjacent to the stopped order.

f. Verbal orders. Verbal order will be confined to emergency "STAT" orders only. The nurse accepting the order must make an entry on the form noting the order, followed by "Verbal order, Dr. Jones/Donna A. Smith, CPT, ANC." The order must be countersigned by the prescriber as soon as possible following the emergency.

g. Telephone orders. Telephone orders will be held to the minimum and accepted only by a professional nurse (with third-party verification whenever possible) and must be countersigned by the prescriber within 24 hours.

2-5. Nursing Process: The Nursing Process is a problem solving systematic thought process which is essential to accomplishment of specific predictable individual care. This process consists of the following 4 elements:

a. Assessment/Appraisal - is the Nursing history, the gathering of data from the patient, from the patient's family or significant others, and from other information obtained from the patient's records or other documentation. Once the Nursing history or interview is finished, the professional nurse then decides what physical assessment needs to be accomplished so that an individual plan of care can be completed. The Nursing assessment must be accomplished by a professional nurse so that all nursing care is professional directed. This assessment phase of the nursing process should be completed within 24 hours of the patient's admission to the hospital.

b. Planning - the development of the Nursing care plan should be devised from the initial and "on-going" assessment if the individual patient's needs. The care plan consists of a problem list, expected outcome or goals to accomplish by the Nursing intervention. Planned Nursing interventions are written as Nursing orders.

(1) The Nursing orders are a vital means of communicating Nursing interventions to all care providers.

(2) The Nursing orders are essential for accountability and responsibility in the documentation of care.

c. Implementation - this phase of the Nursing Process includes Nursing actions determined by the Nursing care plan. The delegation of Nursing care to other care providers is the responsibility of the Head Nurse or designated

charge nurse. The implementation phase concludes when the Nurse's actions are completed and recorded. Therefore, the utilization of Nursing orders/intervention are strongly encouraged and must be documented on the DA Form 4677 (SG Form 8-Test).

d. Evaluation - is always considered in terms of how the client responded to the planned action. Evaluating the effects of actions during and after the implementation phase determines the patient's response and the extent to which immediate, intermediate and long-range goals are achieved. This evaluation phase, like the entire process, must be documented.

2-6. Nursing Process Documentation. The Army Department of Nursing records complement each other so that when the clinical record is reviewed, the documentation will reflect the nursing process, i.e., assessment of the patient, planning, implementing, and evaluating the nursing care to meed the patient's individual needs. All forms must be completed. The nursing care plan consists of

a. An assessment documented on either SF 510 or SF 509.

b. Plans documented as nursing orders on the DA Form 4677 (SG Form 8-Test).

c. Discharge planning and medication instructions documented as a Patient Discharge Plan on Medical Record - Supplemental Medical Data (DA Form 4700). It is suggested that the discharge summary be printed in triplicate; one copy to patient/family, one copy to ITR and one copy to OTR.

d. Evaluation of the patients progress and the effectiveness of nursing interventions as documented on the Clinical Record - Nursing Notes (SF 510) or Medical Record - Progress Notes (SF 509).

2-7. Therapeutic Documentation Care Plan (DA Form 4677-4677-1) (SG Form 8-Test) and Therapeutic Documentation Care Plan (Medication) (DA Form 4678)(SG Form 7-Test).

a. General. These are complementary forms to be used by the nursing staff to identify patient problems, expected patient outcomes, document administration of medications and accomplishment of test, treatments and nursing orders. These forms are used to record actions carried out on a recurring basis or on a one-time or pro re nata (PRN) basis. Separation of medication and non-medication order documentation will provide easier use, organize similar tasks and reduce waiting time for use by large numbers of personnel. Separation of single and PRN from recurring action documentation will minimize the need to recopy orders. These documents are a permanent part of the patient's records. All entries will be made in reproducible ink (black, blue-black) and must be legible.

b. DA Form 4677 (SG Form 8 - Test). This form, printed on colored paper, is used in the same way as DA Form 4678 (SG Form 7 - Test) (c below) for non-medication doctor's and nurses orders.

(1) Medical orders will be transcribed from the doctor's order form.

(2) Nursing orders, initiated by the professional nurse, will be written on this form and must be signed at the end of the order by the nurse initiating it.

(3) As patient problems are identified, record in the appropriate column the data identified, the nature of the problem and the expected outcomes (goals) of planned nursing interventions. Problems will be numbered and initiated to correspond with planned nursing interventions recorded as nursing orders. When a problem no longer exists, the data accomplished will be entered in the proper column and corresponding nursing orders discontinued. The expected outcome will be identified as long (L) or short (S) term goals in the appropriate column.

c. DA Form 4678 (SG Form 7 - Test)

(1) Preparation. Enter all patient identification data as indicated on the form.

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

(3) Primary diagnosis. Enter admission diagnosis or a corrected one, as a definitive diagnosis is made or another condition develops. Add other diagnoses if they significantly affect care to be give.

(4) Data and pagination. Record data requested on each sheet.

(5) Recurring medications.

(a) Order date. Enter date current order written.

(b) Initialing. The individual who transcribes an order must initial the top portion of the box. The nurse must initial the lower portion. The nurse's initial indicates that this person checked the accuracy of the transcription against the order on the doctor's order form and is therefore, accountable for its accuracy and its appropriateness from a nursing standpoint.

(c) Recurring medications. To be used for recurring drug administration or actions when compliance with the order is repetitive and scheduled. The complete order, as originally written, must be transcribed to this section.

(d) Hour. List specific time vertically. Each space is for a separate time administration.

(e) Date. Use the top row of spaces to indicate the day the action is accomplished.

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

(g) Discontinued order. When an order is discontinued, write across remaining blocks: "DC/date/initials." A single line must be drawn through the grid adjacent to the stopped order.

(h) Dispensing times. This legend is to assist in more efficient planning. On the bottom of the page, circle in pencil the hours medications are to be administered. This will help to identify and sign off on medications, by simply checking hours of administration, rather than reading all entries.

(6) Single order, pre-operatives.

(a) Enter in upper right corner, as indicated.

(b) Order date. Enter the date current order is written.

(c) Initialing. (Same as in (5)(b) above).

(d) Single medication. State exactly what medication is to be administered or action taken. Note the route of administration, dosage, time (if known), and any special instructions (juice before eating, use of special syringe, etc.).

(e) Date to be given. Enter date drug is to be administered or action taken.

(f) Time to be given. Enter time drug is to be given or action taken. Leave blank, if unknown. Fill in "on call", if so ordered. Circle time, if not completed. A circle refers the reader to the nursing notes for an explanation of why the order was not carried out.

(g) Time given. Enter time medication was actually administered.

(h) Initials. Person giving medication initials here at the time of administration. This indicates compliance with the order.

(7) PRN medication. Use when time administration is not predictable. All PRN medications are results must also be documented in the Nursing Notes or Progress notes.

(a) Order/Expir (expiration) date. Enter date current order is written in top portion.

(b) Initialing. (Same as in (5)(b) above.)

(c) Medication. Indicate medication to be administered, dose, frequency. Note route or purpose of the drug (e.g., oral medication for pain or rectal suppository for nausea).

(d) Time/date dispensed. Each block indicates a separate action. The person completing the action enters the date, time, and his or her initials at the time of completion.

(8) Copies orders. When space in "Date Dispensed" column is filled, draw a double line across the entire page just below the last medication entry. Directly below this double line, or on a line blank form, fill in dates for coming days and copy each order still in effect to include the doctor's name and the date of the original order. The individual copying the orders, if a clerk, will follow the initialing procedures in (5)(b) above. The responsible nurse will verify these by initialing the proper column. If the nurse transcribes the orders, authentication will be by signature and rank or status at the end of the transcription.

2-8. Clinical Record - Nursing Notes (SF 510).

a. General. SF 510 is a single sheet, identical on both sides, which is maintained in the patient's chart. Nursing notes will be written legibly, and each entry will be followed by the signature and rank or status of the person making the entry. In Medical Treatment Facilities where commanders have approved problem oriented charting, nursing documentation of patient progress using the SOAP format may be done on SF 509 (AR 40-66, para 7-12, b(4)).

b. Preparation. Enter all patient identification, including social security number, and other data as indicated in spaces at the bottom of the form.

c. Admission and discharge notes. Initial entry will include date, time, manner of admission, reported known allergies, and a brief, clear description of symptoms and pertinent observations. In the absence of a discharge planning form, note the date, time, manner of discharge, and concise summary of discharge plan. This will include documentation of health teaching appropriate to the disease and desired behavior outcomes.

d. Content. Nursing notes will contain objective observations of patient's condition, to include physical and mental status, symptoms, response to diagnostic or therapeutic procedures, or changes noted in any aspects of these. The nursing notes must reflect the patient/response/status to all nursing care measures. Since nursing notes aid in diagnosis, furnish reference material for research and teaching, and provide important evidence in event of litigation, it is essential that all entries contain significant and pertinent data relative to nursing care.

e. Medications. Accomplishment of orders for narcotic and PRN or STAT medications will be entered on SF 510 or SF 509. Each entry will include time, medication, and indication for administration. Assessment of effectiveness of action of medication will be noted following administration. If for any reason scheduled medication or treatment is not given, enter this fact and reason for its omission.

f. Special procedures. Diagnostic, therapeutic, and special nursing procedures and unusual occurrences will be described in SF 510 or SF 509. Notation will include time, name of procedure, by whom performed, brief description of what was done, patient's condition before the procedure and during the procedure, and reaction of the patient after the procedure.

2-9. Patient discharge plan.

a. Purpose and form. Use Medical Record-Supplemental Medical Data (DA Form 4700) for this plan. 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 her upon discharge.

b. Preparation. Complete this form in triplicate. The original copy becomes a permanent part of the patient's ITR, the second copy is reviewed with the patient and is retained by him or her, or the family, and the third copy is placed in the OTR. Enter all patient identification information, including social security number, in space provided on the form.

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

2-10. Clinical Record-Pediatric Nursing Notes (SF 536). This form is similar to SF 510 and may be used in place of SF 510 or SF 509 for pediatric patients.

2-11. Medical Record-Vital Signs Record (SF 511).

a. Preparation. Enter patient's identification data and social security number in the space at bottom of form. This form will be maintained in the patient's chart.

b. Recording data. Number the "Hospital Day" line of blocks with day of admission as 1, and continue consecutively. Use the post-day line as applicable. The day of surgery or other event is the operative day. The day following surgery is noted as the first post-operative day. The day and hour blocks will be properly labeled. Represent temperature by dots (.) placed between the columns and rows of dots and joined by straight lines. If route of determination is other than oral, it should be indicated by (R) for rectal and (A) for axillary. Show pulse determination by use of (0) connected by straight lines. Enter respiration and blood pressure on the indicated rows below the graphics portion. Record frequent blood pressure readings on the form's graphic portion by entering an "X" between the columns and rows of dots, at points equivalent to systolic and diastolic levels. Connect the two with a vertical solid line. Use blank lines at bottom of the sheet to record special data such as 24-hour total of patient's intake and output.

2-12. Medical Record-Pediatric Graphic Chart (SF 537). This chart is similar to SF 511 and may be used for pediatric patients.

2-13. Medical Record-Supplemental Medical Data (DA Form 4700). DA Form 4700 will be used to provide supplemental special information to other authorized forms which do not meet local requirements under paragraph 7-3b, AR 40-66. From a nursing standpoint, DA Form 4700 may be used to document signature/initial verification lists, data flow sheets, or the patient discharge plan (see para 2-9).

Note: DA Form 4700 may be used without prior authorization to document signature and initial verification lists.

DA FORM 3888
NURSING ASSESSMENT AND CARE PLAN
SUMMARY SHEET

Most comments regarding the DA form 3888 addressed one or more of the following: the format/structure (specific questions vs open ended guidelines), the redundancy of information, the problems encountered with short term (less than 72 hours hospitalization) and specialty patients, and combining the history with the assessment portion of the DA Form 3888-1.

FORMAT/STRUCTURE

Responses from sixteen institutions noted that the questions contained in the history are awkwardly worded, too lengthy and structured to meet all needs. It was suggested to eliminate questions in favor of providing broad guidance to stimulate the interview process. Another suggestion was to modify the format to allow the patient to complete the information. A form which could be placed in the health record and updated as necessary on subsequent admissions (much like that used in the VA system, Encl 1) was also suggested.

Specific Comments on items of the DA 3888 were as follows:

ITEM	COMMENTS
1.	"on PAD sheet"; "not suitable for short term patient"; "eliminate'
2.	"contained in PAD report-repeated info" "eliminate"
3.	
4.	"contained in PAD reports"; "eliminate"
5.	"MD hx-repeated"; "add more space"
6.	"repeated in NN"; "eliminate"
7.	"repeated in NN"
8.	"repeated in PAD report-eliminate"; increase space for the name of the relative, relationship to patient and pertinent telephone number of primary relative/or significant person"
9.	"incorporate with 11 and 12"; "change to 'admitting diagnosis'"
10.	
11.	"reword...to allow the patient's perception of the illness to be expressed"; "eliminate"; "change to: 'describe your illness and/or reason for hospitalization and what is planned for you here.'...
12.	

13. "reword to read: 'Have you been hospitalized before, for what and how long ago?"; "describe all (more than just recent)"

14. "Change to: 'Are you presently or have you seen a physician for any other health problem?'"; "Reword to include past medical history"; "combine with 13"

15. "add: 'over the counter drugs, e.g., ASA, cold tablets or vitamins'"; "eliminate phrase 'before your admission' in event the patient took his/her own medication after being instructed not to take any medication." "confusing as states - all present medications should be listed"

16. "include 'food, drugs and other'"; "repeated from doctor's sheets-eliminate"

17. "change to read: 'Are you on a special diet? Are there foods which cause you indigestion?"; "omit"; "not referred to once form completed"

18. "omit"; "not referred to later..."; "format doesn't elicit enough information"

19. "Add - 'abdominal pain, blood in stool or urine'"

20. "Add - 'pain, previous UTI, menstrual history, prostatic problems'"; "information in doctor's history - repeated - omit"; "combine 19 and 20 under general heading for 'GI/GU'"

21. "change to 'normal hygiene patterns, usual time for hygenic activities, bath taken in the AM, PM, or noon'"

22. "information not referred to once form completed - omit"; "add 'dentures'"; "include 'contact lens/false teeth'"

23. "confusing as stated, suggest: 'Would you like to see a chaplain while here?"; "omit"; "not suited for short term patients"; "shorten - too wordy"

24. "omit - on doctor's history"; "ask if patient minds sharing room with smokers"

25. "Is this really necessary - will they be forthright, especially if he/she has a problem?"; "found in doctor's history - eliminate"

26. "omit"; "not pertinent for short term patients"; "poorly phrased, difficult to assess"; "not referred to once completed"

27. "poorly phrased; difficult to access"; "omit"; "eliminate or combine with 28. These questions are unclear to the patient"; "not referred to once form completed"; "too soon to ask at admission. Most patients answer with a phrase or statement to 'please' the nurse - not yet built a nurse/patient relationship"

28. "combine with 27. This one could state 'do you tell people that you are upset'"

29. "omit"; "I lump all these (26, 27, 28, 29) by asking 'Is there anything else you'd like to tell me which will help us to take better care of you?...' Then usually the requests for private room, TV, special food, etc come out..."

In addition: "Have a signature block for the patient to sign as verification of the accuracy of the information."

"Have an additional signature block for review purposes to be used if transferred to another ward or for a long term patient."

REDUNDANCY OF INFORMATION

Several of the comments are linked to the redundancy issue. In the survey conducted by the NETS at DDEAMC which constituted their responses, the "nursing history and assessment form was selected more frequently as a form to leave the same than it was selected for change...The principle issue for change is duplication... " As previously noted, many of the comments regarding specific numbered items on the DA 3888 mentioned data contained elsewhere in the medical record, often the physician's history or the PAD report. There were suggestions to combine nursing and physician's history and assessments. Representative comments follow:

"...(there is a problem with) the current State of the Art in recording the patient's health history. The utilization of multiple forms by OR, anesthesia, primary physician and nursing personnel for recording of the patient's health history results in duplication of effort, and often information is not pulled together for the best medical care management... It is proposed that a single patient history form be designed that allows for multi-disciplinary collection and recording of the patient's health history..." FORT BENNING

"...Delete DA 3888 and provide space for nursing history on SF 502 (physician's history and physical) for the documentation of the nursing history and physical. With this policy, assessment and history data collected by one member of the health team would not be repeated by colleagues from another discipline. Additionally, the patient would not need to be asked the same repetitive questions..." ISR

SPECIALTY AREAS/SHORT TERM ADMISSION

Approximately one-third of all responses included a notation of the non-applicability of the DA Form 3888 to a specialty area such as obstetrics, pediatrics and psychiatry. Several institutions included copies of overprints currently utilized to overcome difficulties. The nursing staff at the 121 Evacuation Hospital-Seoul made the following suggestions which combine history and assessment and meet specialty needs:

"Overall, the questions on this form are not very definitive for an assessment at admission. The questions are worded in such a way that they are not very helpful to the professional for assessment purposes and generally are not even that helpful as a 'guide' for assessment. There are some inpatient areas where this form is not only not helpful, but is practically useless. A prime example of this is the Labor and Delivery area; this nursing history form is barely relevant to the antepartum patient preparing for delivery. ICU areas and Pediatrics are other areas where the form is barely useful, even as a guide for assessment."

"Propose that the 3888 and the front of the 3888-1 be converted to a basic assessment checklist or fill-in-the-blank assessment sheet with questions more pertinent to the different inpatient areas. A general assessment with review of systems could be devised that could be used by all nurses on assessment with more specific checklists for each individual area to be completed as needed.

This new assessment sheet would be the only assessment/admission form and would become the SF 510-1, so that information does not have to be repeated on the SF 510 that is already on an admission form (presently being done with DA 3888 and admission note on SF 510). SF 510-1 will be the first nursing note in all patient's charts, will not be an overprint designed by an individual hospital, will be standardized for all Army health facilities, and will include all basic admission information in one place and on one form."

Finally, there is a desire for a "short term" admission history/assessment/care plan guide or form. Common responses in this area again reflected the time necessary to complete the current forms and the frustration in trying to meet requirements only to have the patient discharged within 48 hours of admission!

COMBINATION OF NURSING HISTORY AND ASSESSMENT

The combination of nursing history and assessment was explored by the nursing staff at Fort Monmouth:

"...Condense history-related questions on front of form. Deleting some of the demographic data at the top of the 3888 could assist with this endeavor...Outline a review of systems on the back of the 3888 utilizing a scheme which includes the following: neurological, skin, a scheme which includes the following: neurological, skin, motor skeletal, cardiovascular, respiratory, gastrointestinal, geniturinary, special senses, emotional/social.... If possible incorporate Marjory Gordon's typology of eleven functional health patterns into the history and assessment guidelines (Encl 2)...."

The Principal Investigator (LTC Bell) found a "format" rather than a "form" discussed by nurses at an institution in Boston which combines history and assessment (Encl 3).

Responses from the MEDDAC in Panama (Encl 4), at Fort Carson (Encl 5) and Fort Leonard Wood (Encl 6) were detailed and provided examples of possible options.

Standard Form 507 — ADMISSION DATA BASE — 40-16-61472-8 GPO

CLINICAL RECORD

Report on _____
or
Continuation of S. F. _____
(Strike out one line) (Specify type of examination or data)

DATE: _____ TIME: _____ (Sign and date) UNIT: _____

ALLERGIC REACTIONS: Substance/Symptoms:

INFORMANT _____

NEXT OF KIN: _____ PHONE: _____

ADDRESS _____

BIRTHDAY _____ SEX _____ RELIGION _____ MARITAL STATUS _____

DIET _____ PERSONAL HYGIENE (TYPE, TIME) _____

BOWEL _____ BLADDER _____ SLEEP _____

ALCOHOL _____ TOBACCO _____ DRUGS _____

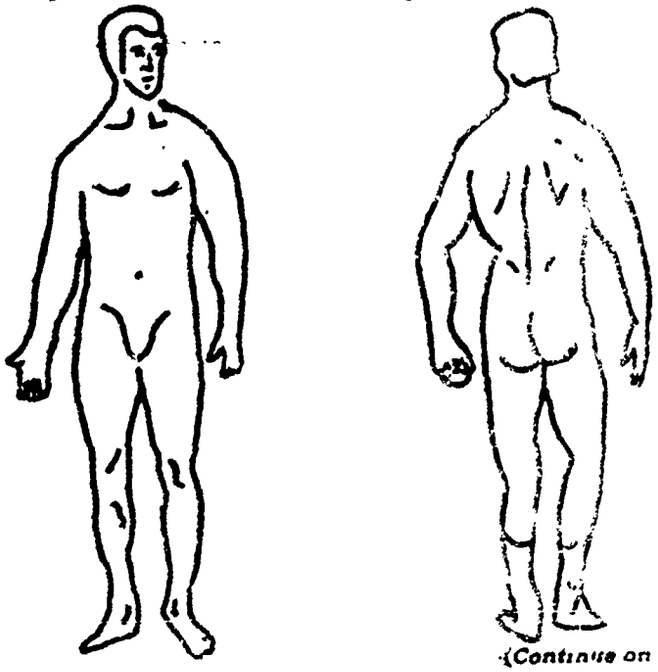
OCCUPATION _____ EDUCATION _____ LANGUAGES _____

VALUABLES: MONEY _____ DISPOSITION: _____

OTHER _____ DISPOSITION: _____

FAMILY OR REFERRING PHYSICIAN _____

Body identification marks (scars, bruises, tatoos, ulcerations, etc.)



PROSTHESIS: GLASSES _____
DENTURES _____ CONTACT LENS _____
LIMBS _____
HEARING AID _____ GLASS EYE _____
HAIR PIECE _____
OTHER _____

MEDICATIONS AND TREATMENTS:

SIGNATURE _____

OP 118-80-4
Apr 1980

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give Name—last, first, middle, grade; date hospital or medical facility) | REGISTER NO. | WARD NO.

REPORT ON _____ or CONTINUATION OF _____

STANDARD FORM 507
General Services Administration and Interagency Committee on Medical Records
FPMR 101-11.80 6-8
October 1975 507-106
U.S. Government Printing Office 1981—341-466/4291

Incl 1

LIVING ARRANGEMENTS (Check one box, add comments if appropriate)

	HOUSING	ABILITY FOR SELF CARE-ADL
☐ A. Spouse		
☐ B. Parents	☐ A. Own Home	HYGIENE _____
☐ C. Relatives	☐ B. Rented Home	FEEDING _____
☐ D. Friends	☐ C. Apartment	TOILETING _____
☐ E. Alone	☐ D. Rented Room	DRESSING _____
☐ F. Institution	☐ E. Mobile Home	MOBILITY _____
☐ G. Other (Specify)	☐ F. Other (Specify)	SELF MEDICATION _____

DATE _____

FULL SIGNATURE _____

ADDITIONAL DATA BASE - Optional

FAMILY MEDICAL HISTORY (For positives, indicate relationship)

☐ 1. Diabetes ☐ 2. Heart Disease ☐ 3. Hypertension ☐ 4. Stroke

☐ 5. Kidney Disease ☐ 6. Cancer ☐ 7. Arthritis ☐ 8. Tuberculosis

☐ 9. Drugs ☐ 10. Alcohol ☐ 11. Epilepsy ☐ 12. Mental Illness (Specify)

☐ 13. Other

PREVIOUS ILLNESS AND HOSPITALIZATION (Specify as to illness, injury, operation. Include dates.)

ADMISSION NURSING NOTE

MEDICAL RECORD	PROGRESS NOTES
DATE	TIME
Subjective:	Patient Concerns and Symptoms:
Objective:	Mode of Admission: (Stated)
	BP/R BP/L T P R HT (Measured)
	(Stated/ WT (Measured)
	Clinical signs and observations; include mental status, disabilities:
Assessment:	Patient's Assets, Strengths, Resources:
	1
	2
	3
	4
	5
	6

(Continue on reverse side)

PATIENT'S IDENTIFICATION *(For typed or written entries give name—last, first, middle grade, rank, rate; hospital or medical facility)*

REGISTER NO

WARD NO

OP 118-80-3
Apr 1980

PROGRESS NOTES

STANDARD FORM 509 (Rev. 11-79)
Prescribed by GSA/ICMR
509-114

PROGRESS NOTES

DATE	Nursing Problems; Nursing Diagnosis, Signs/Symptoms; Admission Status:
	1
	2
	3
	4
	5
	6
	7

Initial Nursing Recommendations for Care:

DOCTOR NOTIFIED NURSE SIGNATURE

TIME

TABLE 3-6
TYPOLOGY OF ELEVEN FUNCTIONAL HEALTH PATTERNS

Health-perception–health-management pattern Describes client's perceived pattern of health and well-being and how health is managed
Nutritional-metabolic pattern Describes pattern of food and fluid consumption relative to metabolic need and pattern indicators of local nutrient supply
Elimination pattern Describes patterns of excretory function (bowel, bladder, and skin)
Activity-exercise pattern Describes pattern of exercise, activity, leisure, and recreation
Cognitive-perceptual pattern Describes sensory-perceptual and cognitive pattern
Sleep-rest pattern Describes patterns of sleep, rest, and relaxation
Self-perception–self-concept pattern Describes self-concept pattern and perceptions of self (e.g., body comfort, body image, feeling state)
Role-relationship pattern Describes pattern of role-engagements and relationships
Sexuality-reproductive pattern Describes client's patterns of satisfaction and dissatisfaction with sexuality pattern; describes reproductive patterns
Coping-stress-tolerance pattern Describes general coping pattern and effectiveness of the pattern in terms of stress tolerance
Value-belief pattern Describes patterns of values, beliefs (including spiritual), or goals that guide choices or decisions

areas of assessment applicable to all clients. The result would be that (1) the domain of responsibility and accountability would be clear, (2) the focus for clinical studies would be identified, and (3) the focus for development of expertise in assessment and diagnosis would be clearly delineated for teachers, students, and practitioners.

A typology of assessment categories proposed in the next section is viewed as a step in the direction of unification of *structural areas*. As stated previously, each nurse's *approach* to these areas is dictated by the conceptual framework utilized.

FUNCTIONAL HEALTH PATTERNS TYPOLOGY

The typology[5] of functional patterns in Table 3-6 contains a set of health-related areas quite familiar to nurses. Client reports and nurses' observations provide the data for identifying patterns.

The clinical information collected under the assessment structure shown in Table 3-6 is relevant to all conceptual models because it is *basic* information. The typology represents both traditional and contemporary ideas of nursing practice in a *concise, easily learned set* of category names.

[5]The pattern areas were identified by the author about 1974 for purposes of teaching assessment and diagnosis at Boston College School of Nursing. Colleagues have suggested some minor changes in labels and content. Faye F. McCain's (1965) and Dorothy Smith's (1968; Becknell and Smith, 1975) assessment concepts were particularly influential, as were the comments of clinical specialists and students who reviewed and tried out the categories in practice.

Incl 2

FIGURE 1.

NURSING DEPARTMENT
Assessment Worksheet

PETER BENT BRIGHAM HOSPITAL
Division of the Affiliated Hospital Center, Inc.

Name.
Date:

Admission/Discharge Diagnosis/Chief Complaint:

I. HEALTH MAINTENANCE SYSTEM

Admitted from/Discharge to: (home, hospital, nursing home, etc.)

Support System: (family, neighbors, friends, relatives, emergency contact)

Pre/Post Hospital Medical Care: (clinic, private MD, neighborhood health center, referrals to agencies)

II. SOCIAL PROFILE

A Cultural, environmental, social,economic, religious, occupational and familial aspects to care:

B. Health Teaching and Plans (risk factors? health hazards?):

III. EMOTIONAL PROFILE:

A. Response to past or present hospitalization

B. Self concept (body image, sexuality)

C Health Teaching and Plans (understanding of disease process and symptoms of recurrence):

IV. PHYSICAL PROFILE:

Vital signs Weight Height Prosthesis

Current Medications Allergies

A. **Review of Systems**

Mental Status (level of consciousness/orientation):

Sensory Status (vision/hearing/speech/aids):

Neuromuscular/Skeletal Status (mobility):

Integumentary Status (condition of skin, wound healing)·

Cardiovascular/Respiratory Status (quality of pulse, respirations, need for assistance, etc.)·

Nutritional Status (type diet/ability to chew, swallow, appetite)·

G.I./G.U Status (major problems or concerns in function)

Sleeping/Rest Requirements (stated needs, habits)·

B. Health Teaching and Plans (medications—side effects, treatments, diet, activity)

V.	PROBLEMS	PLANS

Incl 3

Used with permission

Pandmh

HSXU-NG-NE 4 January 1984
SUBJECT: Review of Nursing Documentation for Inpatient Records

I. Problems. There are two major concerns expressed by our staff with regard to the documentation process:

1) documentation is extremely time consuming due in large part to the double documentation required by regulation and form.

2) implementation of the nursing process is difficult because assessment, identification of nursing problems, nursing interventions, and implementation is split between five forms.

II. Solutions. DA 3888 Medical Record - Nursing Assessment & Care Plan: Collection of the nursing history/data base is an essential step in the nursing process and should be conducted with each new admission. However, not all of the information is pertinent to every patient. After conducting the interview, the nurse should organize the significant information on the current assessment continuation sheet. This would allow the nurse to focus on the information which is predictive of problems. While the DA 3888 has essential areas for interview, the questions as stated are too confining. An approach which would be less confining would be to utilize Becknell and Smith's Clinical Nursing Assessment Tool (Incl 1) as an interview guide sheet which would not be a permanent part of the record. The nurse, at the conclusion of the interview and physical exam, would be required to consolidate all significant information on the DA 3888-1. If the form were overprinted with general category headings (Incl 2), it would facilitate organizing the information. Please note that a statement regarding valuables was included as this seems to be a piece of information which is frequently missing.

If the current forms, DA 3888 and 3888-1, were to be retained, information like address, telephone, height, weight, and next of kin should be viewed as double documentation of information which is more appropriate to another form. The nursing admission note on the SF 510 required by AR 40-407 is also viewed as double documentation, and the requirement should be eliminated. The nursing history and assessment should stand alone as the essential information required for admission.

The nursing care plan which identifies patient problems should not be on the back side of any form. The data is so significant to the delivery of patient care that it should be easily retrievable and seen at first glance. The current form should be revised to include patient problems/patient goals and nursing interventions utilizing Marlene Mayers format. Problem statements must include potential as well as actual problems since there are many specific nursing interventions geared to preventing problems, i.e. deep breathing and coughing post surgery, cast checks post cast application, etc.

Discharge considerations are so essential to the delivery of nursing care that the discharge needs should be a part of the care plan problem statements, thus eliminating the separate section now reserved for discharge considerations. The revised form as suggested is attached (Incl. 3).

Incl #1

FIGURE I CLINICAL NURSING ASSESSMENT TOOL
Nursing History

1. *Vital statistics.*
name, age, sex, wt. hgt, marital status, residence, admissions

2. *Patient's understanding of illness.*
why in the hospital, effects illness has had on living habits

3. *Some indications of patient's expectations.*
what will occur while in the hospital, what will result from stay in the hospital, what he expects of nursing care

4. *Brief social and cultural history.*
occupation, on aid, religion, education—if 4th grade read and write, immediate family members, lives with or alone—most significant person, animal, job, church

5. *Significant data in terms of:*

a. *Sleeping patterns.*
to bed, wakes—gets up, bedtime rituals, any difficulty going or staying to sleep if so, what happens, what's done, # pillows

b. *Elimination patterns.*
BM's—time, frequency, aids, what, when, any difficulty, how is it prevented/alleviated

c. *Breathing patterns.*
probs, when—what makes it worst/relieves it

d. *Eating and drinking patterns.*
meals—time, typical menu, *snacks*, likes, dislikes, restrictions, probs, does it affect ability to eat, what assistance is needed, smoking per day, drinking per day, drugs per day

e. *Skin integrity.*
color, turgor, texture, state, describe any problems observed, how pt. cares for skin—prevent/alleviate probs, bath—frequency, time, kind, shave—frequency, time *makeup*, teeth—frequency, time, denture in/out, for hs, any help needed with bath, teeth, grooming

i. *Activity.*
able to walk, limitations, how it affects ADL, R.O.M. describe limited part/how it affects ADL, what assistance is needed due to limitations

g. *Recreation.*
what is done for relaxation, leisure, hobbies

h. *Interpersonal and communicative patterns.*
how does patient feel with new situations/people, describe nonverbal and verbal behavior

i. *Temperament.*
what makes patient angry, what does he do when angry, how does he let others know he's angry

j. *Dependency and independency patterns.*
what he does for self, others, has others do for him. How he lets others know what he wants, how he feels when asking and accepting help.

k. *Senses.*
sight—any problems, how it affects ADL, what can others do to help, hearing—any problems, how it affects ADL

l. *Menstrual patterns.*
frequency, duration, probs., solution

m. *Statement of that which helps pt. feel cared for.*
describe items of importance to pt. (security, comfort, protected, safe). What do others do or have done to make patient feel cared for.

Adapted From: NURSING HISTORY by
Dorothy M. Smith &
Eileen Pearlman Becknell

continued on page 46

MEDICAL RECORD – NURSING ASSESSMENT

For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.

NURSING HISTORY/[redacted] ASSESSMENT DATA

I. Vital Statistics/Social & Cultural History:

II. Patient's Understanding of Illness and Expectations:

III. Systems Review/Significant Data in Terms of:

IV. Valuables Brought with Patient:

SIGNATURE *(Nurse)*	DATE

PATIENT IDENTIFICATION

Inclosure 2 To Incl 4

INSTRUCTIONS: Number and initial each recording and indicate Long(L) and Short(S) term goals.

DATE IDENTIFIED	PROBLEMS	EXPECTED OUTCOMES *(Goals)*	L/S	DATE ACCOMPLISHED

DISCHARGE CONSIDERATIONS:

Patient-Family Teaching:

Special Considerations: *(Sociopsychological needs, Limitations, Disabilities, etc.)*

Other:

Post Hospital Disposition:

NURSING INPATIENT DOCUMENTATION OF CARE FORMS

CRITIQUE SHEET

FORM NUMBER DA Form 3888 (Continued)

PROBLEM AREA	COMMENTS ABOUT PROBLEMS	SUGGESTIONS FOR CHANGE
In general, the forms should be a complete working document which reflects the nursing process. Many staff members feel all licensed Department of Nursing personnel should be permitted to complete these forms. Allowing LPNs or their equivalents to complete the form would make the language more understandable to all users regardless of skill level. Further, their completing the form would help distribute the responsibility to a greater number of staff. This would increase the likelihood that more of them would be completed. A secondary gain would be this: The professional nurse would be available to care for or more directly supervise the care provided the more acutely ill or more complex cases. Should all licensed personnel be allowed to complete these forms, the co-signature of a professional nurse should indicate that he/she has reviewed, verified the form's contents and is willing to assume responsibility for the data contained therein. Overprinting should be permitted at the discretion of the Chief, Department of Nursing, at the respective facility. Many staff nurses have not internalized the Army Medical Department Standards of Nursing Practice. Standard I identifies the minimum amount of data that should be included on the DA Form 3888-1, Items 2 (a through i). The requisite minimum data's parameters could be overprinted on the DA Form 3888-1 when printed by DA. Further, a statement should be included in the overprint indicating that data on biophysical status in the appropriate area (physiological subsystem in which pathology has occurred) is required which would contribute to a meaningful nursing care plan.		

Incl 5

MEDICAL RECORD – NURSING ASSESSMENT AND CARE PLAN

For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.

DATE / TIME 1. NAME, ADDRESS & TELEPHONE OF NEXT KIN 2.

NURSING HISTORY	YES	NO	INSTRUCTIONS. USE PATIENT'S OWN WORDS WHEN POSSIBLE. USE ITEM NUMBER FOR EACH RESPONSE.
3.			What brought you to the hospital? Have you been hospitalized before? Do you have any other health problems?
4.			Do you have any allergies or sensitivities? If yes, explain and describe reactions.
5.			Are you presently taking any medications? If yes, name, frequency, reason, last time taken, meds brought to hospital.
6.			Are you on any special diet?
7.			Do you have any problems with your bowels (diarrhea, constipation)? Aids used? Urinating problems (frequency, burning, urgency or other)? If yes, explain.
8.			Do you smoke or drink alcoholic beverages? If yes, amount and frequency?
9.			Do you have any trouble sleeping? If yes, explain. Aids used?
10.			Do you have any special concerns or requests that will help us to make your hospital stay easier? (i.e. assistance with activities of daily living. Use of special aids such as glasses, crutches, etc. and/or particular likes and/or dislikes or religious or cultural practices.
11.			When you go home, who do you have to assist you?

SIGNATURE (Nurse) | Information obtained from: | DATE

PATIENT'S IDENTIFICATION | REGISTER NO | WARD NO

Incl 6

EXAMPLE # 2

(over)

DA FORM 1 AUG 79 3888 EDITION OF 1 JUL 72 IS OBSOLETE (CONTINUE ON REVERSE)

MEDICAL RECORD – NURSING ASSESSMENT AND CARE PLAN (Continuation)

For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General

ADDITIONAL ASSESSMENT DATA

EXAMPLE # 2

SIGNATURE *(Nurse)*	DATE

INSTRUCTIONS: Number and initial each recording

DATE IDENTIFIED	PROBLEMS	DATE ACCOMPLISHED

DISCHARGE CONSIDERATIONS:

Patient-Family Teaching:

Medical Record-Nursing Assessment and Care Plan (DA Form 3888 and DA Form 3888-1). It was the general consensus of the committee that the 3888 and 3888-1 are excellent forms if utilized in an educational setting, but are not practical if used on a continual basis or required on every patient admitted to the hospital. It is suggested that the two forms be combined into one and that all the unnecessary material be omitted as follows:

(1) The original numbers 1 thru 5 should be omitted since this information is provided on the Admission Cover Sheet (DA Form 3647) and addressograph plate provided by Patient Administration Division upon admission. Add to the form: number (1) for Date/Time and number (2) for Name, Address, and Telephone number of next of kin.

(2) Numbers 6 thru 10 could be omitted except for the source from where information was obtained. This could be added at the end of the Nursing History in the column with Signature (nurse) and Date.

(3) The Nursing History section is entirely too long and there are too many questions that are not pertinent or that repeat others. Emphasis should be placed on obtaining information on the patient's knowledge about their diseases, medications, allergies, special diet, and if there is support at home upon discharge. Many of the questions that are asked are answered during the course of the patient's assessment.

(4) Additional Assessment Data: Each specialty area in nursing should be allowed to develop their own overprinted assessment tool to provide the required information.

(5) Instructions: It is recommended that expected outcomes (goals), long and short, be omitted from this section. Subjective and objective problems are either accomplished or deferred regardless of the expected outcome. This will eliminate excessive writing that is not realistic and time consuming.

(6) Discharge Consideration: This entire section could be eliminated if a standardized Discharge Plan (DA Form 4700) was developed and implemented, or each Department of Nursing would develop their own Discharge Planning Form.

(7) See example #2, Inclosure 6.

DA FORM 3888-1
NURSING ASSESSMENT AND CARE PLAN (CONTINUATION)
SUMMARY SHEET

Comments regarding the DA Form 3888-1 were directed at either the "additional data" portion or the Nursing Care Plan and Discharge Considerations located on the reverse side of the form.

ADDITIONAL ASSESSMENT DATA

Comments often reflected a desire to have more rather than less guidance:

> "...(there is a problem with the front of the form being blank)... its' effective use requires thorough preparation of the professional staff in physical assessment, something not always possible.... (We suggest providing) a standard overprint for review of systems which allows fill-in-the-blank completion by RN..." FT DEVENS

> "...standard forms which provide guidelines, i.e., ROS head-to-toe with some common comment..."

> "...It is suggested that the assessment criteria from DA PAM 40-5 standard 1 page 2-1, 2-2, be overprinted on DA Form 388-1 and utilized throughout the Army to reduce the number of different overprints in current use..." FT BENNING

Often the comments seemed to reflect a lack of understanding of the Nursing Standards which do not mandate a total review of systems, but merely "pertinent" areas. Other comments about this section again reflected the concern for duplicated information:

> "...The current methods for documentation of the physical assessment findings among the health care professionals results in duplication of effort and sometimes patients even question as to whether we talk to each other...(It is recommended)...that the DA 3888-1 record only the data that is appropriate for planning care and even then not to duplicate the data recorded by the primary physician...In addition, the initial nursing admission note could best be written on DA 3888-1 to include admission data and other pertinent information and eliminate the recording on SF 510..." FT BENNING

> "...Since the majority of us do not do assessments by systems, this page is usually a repeat of the admission note on the SF 510 or left blank - I'd eliminate it..." FT WAINWRIGHT

NURSING CARE PLAN

Comments addressing this section of DA Form 3888-1 emphasized the need for additional space and the need to incorporate nursing action orders/interventions with the problem list. Thirty-five (out of 46) of all the letters received in response to the request for input to this study mentioned these two items. Other comments expressed concern for having the care plan meaningful for para- professionals and suggested additions or deletions to column headings.

Representative comments follow:

"...Remove nursing order from DA Form 4677 (Documentation care plan - Nonmed.), place them on DA Form 3888-1 (Nursing assessment and care plan). Many nursing orders don't fit well under routine blocks but would be overlooked under PRN, results in much ineffective initialing. More important, including the interventions (nursing orders) on the 3888-1 would more clearly explain their relationship to the problem and the goals. This concrete connection is especially important for the paraprofessionals."... FT GORDON

"...Utilize entire front side of form for the nursing care plan... position the (NCP) format lengthwise on the paper, utilizing the length rather than the width of the paper would allow for a greater amount of space for the care plan..." FT MONMOUTH

"...Commit (the Corps) to the use of the nursing diagnosis..." FRANKFURT

"...the (NCP) needs more space for goals and outcomes...forms should include a problem list which is ongoing and updated...It would be advantageous to couple nursing orders to the nursing care plan. Recommend that the problem list goals and actions be located together to avoid going to several forms for the total care plan...the system must provide a way for the individual at the bedside to have rapid access to basic and concise instructions on the individual patient's care requirements..." FT CAMPBELL

"It is proposed that blank forms with expanded room for problem list, planned nursing intervention and outcome criteria be developed with concomitant space for discharge planning needs and patient teaching needs...it is recommended that a Kardex-type approach be utilized and that specific areas for check-offs be provided..." ISR

"...The care plan portion should be a full page at a minimum with the headings of Nursing Diagnosis, Related To, Goals, L/S, Date Evaluated, Date Accomplished, and a space provided for the nurse who wrote the diagnosis to initial. Nursing Orders need to be written on this form..." WRAMC

"...Expand the (NCP) to include nursing diagnoses, expected outcome followed by nursing actions. Recommend each nursing action on the (NCP) have times listed for each action and spaces to initial that the action was performed. This would eliminate the need to place nursing orders on the Nontherapeutic Documentation Care Plan..." DIX

"...a) (suggest) the following headings for the care plan: Date-initial/Problem/Goal-Expected Outcome/Nsg Action/Problem Resolved. ...specify discharge planning and teaching needs: Date-Initial/ Problem/Outcome-Goal-Date/Comprehensive Learning Status/Nsg Action

b) Patient Goal/Outcome (should) be changed to Nursing Orders, with more space allowed. Once nursing orders are written on the 3888-1 they should not have to be written on the 4677..." FT McCLELLAN

"Change 'Problem' to 'Nursing Diagnosis'..."

"Remove 'Long' and 'Short Term' column"

"develop a continuation sheet for problems/goals, or just problems/goals, or just provide more space..."

DISCHARGE CONSIDERATIONS

Most comments in this section were ones which followed suggestions combining the nursing history and assessment in one form. Allowing the nursing care plan to be on the front portion of a second form and thus discharge and teaching concerns could appear on the reverse side of the nursing care plan. The duplication of information theme was heard again: if discharge arrangements and patient teaching were to be documented here, why a repeat in the nurses notes and again on a discharge form? Several responses suggested eliminating the space for discharge information to make it part of the ongoing problem list in the care plan. Another suggested a separate sheet to note discharge considerations and all patient teaching which would eliminate the need to reiterate the information in the nursing notes.

MISCELLANEOUS COMMENTS

Responses from eight facilities specifically addressed the concern that the DA Form 3888-1 is not pertinent for specialty areas such as pediatrics, obstetrics, psychiatry and newborn nursery. Examples of overprints (either on the 3888-1 or DA Form 4700) currently in use at separate facilities were included in the respondents' letters.

Several responses discussed allowing all licensed personnel (e.g., LVN/91C/and RN) to assess and formulate plans, with final review performed by the RN. However, interpretation of Standard IV of the JCAH guidelines for Nursing Services states "...Each patient's nursing needs shall be assessed by a registered nurse... A registered nurse must plan each patient's nursing care.

DA4256 Clinical Record-Doctor's Orders

Summary Sheet

The overwhelming majority of comments dealt with the problem related to the need to transcribe every order from this form to either the DA 4677 or 4678 (e.g., "time consuming," "increase the risk of error"). Most responses reflected the desire to have an order sheet on which the nurse could note the completion of the action. JCAH Standard for Pharmacies require that a pharmacist review either the direct order or a copy thereof, hence, a carbon copy would remain a requirement.

It was suggested that one way to assist in relieving some of the problems would be to have a separate order sheet for medications. Another response dealt with the single actions:

> "The Doctor's Orders...probably has the greatest impact on the entire nursing documentation process. With some revision of this form, the one time (single action) transaction for treatment and medications could be recorded on the Doctor's Orders form. This would eliminate having to transcribe the orders to the Therapeutic Documentation Plan (DA Form 4677/48)."

A point of Reference for this form and the DA 4678 (medication sheet):

> The Principal Investigator met with COL LeFleur, C., Pharmacy Service, BAMC, and his assistants. COL LeFleur shared several copies of "old" order sheets he has kept on file. (Encl 2-6.) All were forms which had been used prior to the current DA Form 4256 and contained areas for nursing action notation directly beside the original order. He commented that although the nurse could sign off the medication directly on these sheets, the need remained to <u>recopy</u> the order onto a medication card! With the unit dose/sterile products programs in use at essentially all in-patient facilities at this time, and the use of the unit dose medication card, the medication card would prove to be not only an impediment to administering medications, but, because it is NOT a permanent part of the record, would necessitate the nurse's signing off the drug on the physician's order sheet. His points were twofold: 1) the nurse would still need to recopy a medication order (e.g., onto a nonpermanent portion of the record (such as a medication cardex); and 2) if notation of the action was required on the physician's order sheet, further problems of accessibility to the order sheet and the possible tendency of the nurse to sign off all medications at one point in a shift, rather than when they were actually given might arise. He feels a return to the medication card system would not only be a step backward for the profession, but it would create additional difficulties for the nurse, as well as pose quality assurance problems.

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form [illegible] the Surgeon General

THE DOCTOR SHALL RECORD DATE [illegible] ORDERED IN [illegible] RECORD
SYSTEM IS USED WRITE PROBLEM [illegible] BELOW.

PATIENT IDENTIFICATION				DATE [illegible]	TIME OF ORDER HOURS	LIST TIME ORDER NOTED AND SIGN	LIS TIME ORDE
NURSING UNIT	ROOM NO	BED NO					
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER HOURS		
NURSING UNIT	ROOM NO	BED NO					
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER HOURS		
NURSING UNIT	ROOM NO	BED NO					
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER HOURS		
NURSING UNIT	ROOM NO	BED NO					

EXAMPLE # 1

FORM 4256 APR 79 REPLACES EDITION OF 1 JUL [illegible] WHICH MAY BE USED

C-34

Back 1

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DOCTOR'S ORDERS – DDEAMC FORM 1243
30 SEP 75

SHIFT			SHIFT			SHIFT			SHIFT			SHIFT			SHIFT			SHIFT			SHIFT		
D	E	N	D	E	N	D	E	N	D	E	N	D	E	N	D	E	N	D	E	N	D	E	N

Page 2

C-35

BEFORE WRITING ORDER–BE SURE YELLOW IS SHOWING ➡

SERVICE NO	WARD	AT THE END OF EACH T NURSE WHO COMPLETED ORDERS WILL PLACE OWN INITIALS IN PROPER COLUMN

DOCTOR'S ORDERS - *(SIGN ALL ORDERS)*

For Each Set of Orders, Record the Date and Time, Sign and Cross Out the Unused Lines

PATIENT IDENTIFICATION	DATE OR ORDER	TIME	NURSE'S SIGNATURE
NURSING UNIT / ROOM NO. / BED NO.			

PATIENT IDENTIFICATION	DATE OF ORDER	TIME	
NURSING UNIT / ROOM NO. / BED NO			

PATIENT IDENTIFICATION	DATE OF ORDER	TIME	
NURSING UNIT / ROOM NO / BED NO			

PATIENT IDENTIFICATION	DATE OF ORDER	TIME	
NURSING UNIT / ROOM NO / BED NO			

AF FORM 3066 MAR 74

REPLACES DD FORM 728, JUL 53, WHICH IS OBSOLETE IN THE USAF.

☆U.S. GOVERNMENT PRINTING OFFICE 1975-579-145

Place form on firm surface, use pressure for ball point pen

Nurse: Remove one copy and send to Pharmacy after each order is written

☆ GPO 1973 820-869

Standard Form 508
Rev. January 1966
Promulgated
By Bureau of the Budget
Circular A-32

CLINICAL RECORD

DOCTOR'S ORDERS
(Sign all orders)

DATE AND TIME START	DATE AND TIME STOP	℞	DRUG ORDERS (Another brand of a generically equivalent product, identical in dosage form and content of active ingredient(s), may be administered UNLESS checked here).	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
			Incl 4		

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name – last, first, middle; grade; date; hospital or medical facility)

REGISTER NO.	WARD NO.

DOCTOR'S ORDERS
Standard Form 508
508 - 107-01

(D) DAY, (E) EVENING, (N) NIGHT

AR

DOCTOR'S ORDER

(USAMEDCOM Reg 40-110)

AE FORM 3536 1 NOV 77

ORIGINAL ORDERS SIGNED BY DOCTOR
WHEN COPIED, NURSE SIGNS DOCTOR S AND OWN NAME

DATE DISC

DOCTOR'S INITIALS

SHIFT D E N

LEAVE BLANK-USE BALLPOINT- PRESS FIRMLY

LEAVE BLANK-USE BALLPOINT- PRESS FIRMLY

LEAVE BLANK-USE BALLPOINT- PRESS FIRMLY

SERVICE NO | WARD | AT THE END OF EACH SHIFT, NURSE WHO COMPLETED ORDERS WILL PLACE OWN INITIALS IN PROPER COLUMN

NAME	GRADE	REGISTER NO	AGE	DATE OF ADM	DIAGNOSIS

EXAMPLE # 1

DA FORM 4677 (Therapeutic Documentation Care Plan Non-medication)
DA FORM 4678 (Therapeutic Documentation Care Plan Medication)
Summary Sheet

Comments about both the DA Form 4677 and 4678 (Therapeutic Documentation Care Plan) reiterated two themes: the duplication of effort in having to chart information in multiple areas of a patient's record and the time required to recopy every order. Suggestions for revision/improvements were aimed at decreasing or eliminating both problems. All forms in our documentation system are intertwined and comments addressing the "TDs" relate to the DA Form 4256 (Doctor's Orders, the SF 510 (Nurses Notes) and the DA 3888-1 (Nursing Care Plan). Often the suggestions involve not eliminating a piece of data, only directing it to what seems to be a more logical location to facilitate continuity of care. In addition, nurses are concerned that the format of the DA Forms 4677 and 4678 (some orders on the front, single/PRN on the back) is often the cause of medication and nursing care errors: more frequently an error of omission rather than commission. The use of multiple forms to record nursing observations and medical orders adds to confusion, fragmentation of care and frustrations, not to mention time away from the patient to "do paperwork." A few representative comments follow:

> The entire system for noting orders and transcribing them onto other forms (DA 4677 and 4678) is not only too time consuming but provides a perfect mode for potential error. The more people involved in and/or times information is communicated, the more potential for problems. I strongly suggest a system similar to the 'old' way. Everyone reads and carries out the original order (unless orders are copied). Medication list (card) should be used in conjunction with the orders. The chart should be a single entity not spread out in 2 or 3 areas. I appreciate the need for accessibility, however I think the disadvantages associated with the dismemberment of the chart, such as med errors, disjointed documentation, lost documentation, far outweigh the advantage of accessibility...." FT RILEY

> "Signing the TD to indicate an order has been carried out is presently not enough documentation...If the patient has an order to ambulate and does so without problems, I think initialing the TD without documenting in the SF 510 is sufficient...." FT EUSTIS

> "...(the current system of recopying orders) is complex and time consuming...Nursing units without clerks have difficulty keeping up...recurring med errors directly related to form design have been noted...the most frequent error related to the form is omission of single doses, particularly when required to be given at a later date...."

> "...these forms (4677 and 4678) probably create the most distress. Most problems result from the copying of information and the potential for error. Many times, the forms become illegible due to copying; nurses handwriting and too many orders placed too closely together...The major irritation of these forms is the duplication.

also be on 510. This is a consideration for dressing, treatments anything which has a potential for requiring a report...." FT IRWIN

A comment from one Chief Nurse was particularly succinct:

"...A personal note - one of the reasons I immediately liked the Army and stayed was the simplicity of the Old Cardex System. It required little or no need for orientation, errors were quickly noted, and other than the chore of recopying orders, little tedious copying was required. Last weekend, I worked on the Med-Surg Ward and was absolutely amazed at the amount of work our present system required. One page of complicated orders took one hour to transcribe! It must be terrible to work on an oncology or metabolic unit."

The comments from Ft Benning were reiterated in a similar form from nurses at Ft Belvoir and William Beaumont:

"...The current method requires the transcription of orders to two separate books (medications and nonmedications) in two different locations. This method is cumbersome and time consuming...(It is recommended that) the physician order sheet be revised to allow for daily documentation of medication activities and allow for documentation of activities. While this would require the physician to separate his/her orders, it would reduce all transcription of medication and treatment orders. This would facilitate the record and would reduce the number of transcription errors."

Some comments about the DA Form 4677 and 4678 were general, expressing the frustrations, anger and concern with our system and outlining the afore mentioned problems. Others addressed problem areas and provided examples of possible solutions; different formats, overprints, etc., development of an activities of daily living form which might assist in reducing note duplication and transcription time:

"...The time required to write orders for ADL on the nonmedication form exceeds the time available. It is recommended that an overprint nonmedication for be developed that allows for assessment and documentation of ADL needs on the same form...." FT BENNING

Packets received from the Department of Nursing of the USA MEDDAC Panama and USA MEDDAC Ft Leonard Wood provide examples of a total documentation effort, including ADL checklists. The Panama packet contains an article in nursing documentation which references an aid to accurate and time efficient charting.

Similar suggestions for corresponding sections on both forms were often made:

a. Encl 1 (DF from CPT Lupo) discusses the use of a coding system to note evaluation of the nursing intervention on the 4677. A similar suggestion is made to note the effectiveness of medication on the 4678 (Encl 4) Similar comments were made from nurses at 15 other facilities.

b. The PRN areas on each sheet were described as "too small" and need to be enlarged.

c. Having single action orders on the back of either sheet increases chances of omission errors. Common suggestions were to develop a form for only single actions to be directly signed off on the order sheet when completed (Encl 5, Ft Leonard Wood).

d. Delete "action time from the 4677" and "dispensing times" from the 4678. All of the responses which included this suggestion noted that these area are rarely, if ever, used.

e. The use of yellow markers becomes a problem leading to confusing and "messy" papers. Suggestions included the use of a single line drawn through the order with a pen, followed by initials and a date.

g. Delete "additional pages in use."

h. Delete "month and year" - can be provided with recording of the order date in the left hand column of both forms.

DA Form 4678

There were other comments which specifically addressed this form. Several comments expressed concern about not having a system which readily indicates administration times. A representative sample of comments includes:

"DA 4678 should contain some means of indicating when drugs must be given without having to check through every page...." FT MONMOUTH

"...The problem most frequently associated with DA Form 4678 is missed doses, especially medications not given at standard times. The forms must be supported by a flagging/signal alert system which permits rapid identification of the next medication delivery time...." FT CAMPBELL

"...(there is a problem with) identifying med times readily and reliably...develop a better system for flagging times and special meds...." FT BELVOIR

Several comments also addressed the placement of PRN orders vs single action drugs, for example:

"...PRN medications should be on the top...(they) are used more frequently and the top...is more accessible...single dose medications would be on the bottom of the form...." FT STEWART

Several comments addressed the problem of placement of orders such as a sliding scale of insulin or decreasing dose of steroids.

Finally, there were comments regarding the fragility of the current forms. Several responses suggested the design of a more sturdy form, e.g., cardboard consistency.

"...pages of record are not secured in binders. Holes holding pages in rings of binder tear, fall out, get lost...need to have a medication cardex rather than loose leaf binders...with two parts to the medication sheet rather than front and back side."

PRN MED — Top part of Cardex

Recurring Meds — Bottom part of Cardex

With this type of lay-out all information is visible at one glance."

The idea that I'd like to submit, borrowed from Dr. Pardee, University of Washington, Seattle, would be to simply add a code symbol to reflect evaluation of nursing intervention on the green "TD" form. The code would be as follows:

+ satisfactory/within normal limits
- unsatisfactory (must elaborate in the nurses notes)
0 not observed/omitted (must comment in nurses note)

Please see the attached "TD" as an example.

(worthy of consideration)

Thank you

DA FORM 1 FEB 62 2496 REPLACES DD FORM 96, WHICH IS OBSOLETE.

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*
For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.

Mo. Dec Yr. 83

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 1	2	3
1 Dec 83	mcc	VS q 4h c B/p	04	mcl +		
			08	mcl +		
			12	mcl —		
			16	(mcl)		
			20	mcl +		
			24	mcl +		
1 Dec 83	mcl (M)	dipstick urines and	08	mcl +		
		guiac stools	16	mcl —		
			24	(mcl)		

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO _____

PATIENT IDENTIFICATION:

\+ satisfactory/within normal limits
\- unsatisfactory
0 not observed/omitted

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	04	05	06	07

C-45

DA FORM 1 OCT 78 4677 — EDITION OF 1 DEC 77 MAY BE USED

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
Example	#1		VS q 4h ± B/P's. The nurse would note what was not WNL at 1200 (↑ fever (24)) in the notes & note further action taken. She would also note why the 1600 VS were omitted (e.g. pt. off the ward for a procedure).
Example	#2		DS urines and guaic stools: A note must be made regarding what was not satisfactory or normal about the stool or urine (e.g. elevated urine glucose or guaic + stool). The 2400 readings omitted because, for example, no elimination or stool that shift.

☆ U.S. GPO 1976 O-241-510/3105

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)* For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo.____ Yr.____

VERIFY BY INITIALING [redacted] *INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION*

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED

DA 4678 Therapeutic Documentation Care Plan (Medication):
Incorporate space in the PRN section to document effect of the medication and IM injection site, thus eliminating the need for double documentation of this information in the nurses notes. Eliminate the action times section of the form [illegible].

PATIENT IDENTIFICATION:	ALLERGIES ☐ YES ☐ NO	PRIMARY DIAGNOSIS
	Physician	Room Number/Bed

Incl 2

DA FORM 1 FEB 79 4678 EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED.

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*					Mo. ____ Yr. ____
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials	

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION* DATE & TIME, SITE & INITIALS; E if EFFECTIVE						

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo.____ Yr.____

VERIFY BY INITIALING | INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED
5Dec83	-----	Valium 5mg PO		
	-----	QiD		
	-----	John Doe, MD, MC		

	-----	Physician writes orders directly on TD sheets		
	-----	& due Taught to leave sufficient space		

	-----	Nsg orders written directly on Chart		
	-----	form to eliminate the need		
	-----	to transcribe previously ordered		

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

Inst 3

DISPENSING TIMES

USE PENCIL, CIRCLE MED TIMES

D 7 8 9 10 11 12 13 14

E 15 16 17 18 19 20 21 22

N 23 24 01 02 03 04 05 06

C-49

DA FORM 1 FEB 79 4678 EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED.

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General	Mo. July Yr. 83

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 19	20	21	22	23	24	+
19 July 83	[illegible]	Valium 5mg PO q 6°	06	[illegible]	[illegible]					
		"	12	[illegible]	[illegible]					
		"	18	[illegible]	[illegible]					
		"	24	[illegible]	[illegible]					

Explanation of -) (-) method of documenting the effects of controlled substances:

A. A (+) indicates the given medication achieved the results for which it was given.
   ie: if given for pain, pain was relieved.
   ie: if given for agitation, the patient is less agitated

   A (-) indicates the given medication did not achieve the results for which it was given.
   ie: if given for pain, and pain was not relieved.
   ie. if given for agitation, and patient is still as agitated.

B. Can be used for all controlled substances, be they routine, one time, or PRN orders.

C. Can be used for PRNs other than controlled substances (ie MOM, Mylanta etc.)

D. When employed, the (-)'s have to be reflected in the nursing notes (SF 510), the (+)'s do not.

ALLERGIES: ☐ YES ☐

PATIENT IDENTIFICATION:

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

END.

A system is needed to quickly document reaction to routine medications. There are so many drugs for single patients, it is wasteful of time and resources, requiring nurses to continuously document repetitive medication. A + or - systems found in Inclosure VII is suggested or perhaps Inclosure VIII which is used in the VA system and is appreciated by a select nursing staff when used on a trial bases at WRAMC.

DA FORM 4678 Incl 4 EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED.

ENCL - 7

Verify by Initialing

THERAPEUTIC DOCUMENTATION CARE PLAN
(MEDICATIONS)

Mo. _____ Yr. _____

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
19 July 23	RL	Demerol 100 mg IM Stat for pain	19 July	2130	2130	[illegible]

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED			
19 July 22 July	RL	Librium 50-75 mg PO q4° PRN agitation	Date	19 July	20 July	20 July
			Time	2400	0400	0800
			Dose	50	75	75
			Effect	+	—	+
			Init.	RL	RL	RL
19 July 22 July	RL	MSO4 8-10 mg IM q3-4° PRN pain	Date	19 July	20 July	20 July
			Time	2100	0150	0600
			Dose	8 mg	10 mg	10 mg
			Route	IM	IM	IM
			Site	RUOQ	LUOQ	LA
			Init	RL	RL	RL
			Effect	+	+	—

MEDICAL RECORD – SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-400; the proponent agency is the Office of The Surgeon General.

REPORT TITLE: PRN AND ONE TIME MEDICATIONS

OTSG APPROVED (Date)

DATE TIME	DOSE-ROUTE MEDICATION	INITIALS	REASON FOR ADMINISTRATION	EFFECTIVENESS

(Continue on reverse)

PREPARED BY (Signature & Title) | DEPARTMENT/SERVICE/CLINIC | DATE

PATIENT'S IDENTIFICATION (For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)

- ☐ HISTORY/PHYSICAL
- ☐ FLOW CHART
- ☐ OTHER EXAMINATION OR EVALUATION
- ☐ OTHER (Specify)
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

DA FORM 1 MAY 73 4700

WARD 56 (TEST) Chap VIII

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)* For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo.____ Yr.____

VERIFY BY INITIALING | INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED
Needs to have Bath. once"	-----			
also once automatic	-----			
Stop date Must	-----			
the Acknowledge	-----			

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

Encl IX

Is this allergy since the pt was receiving Atarax?

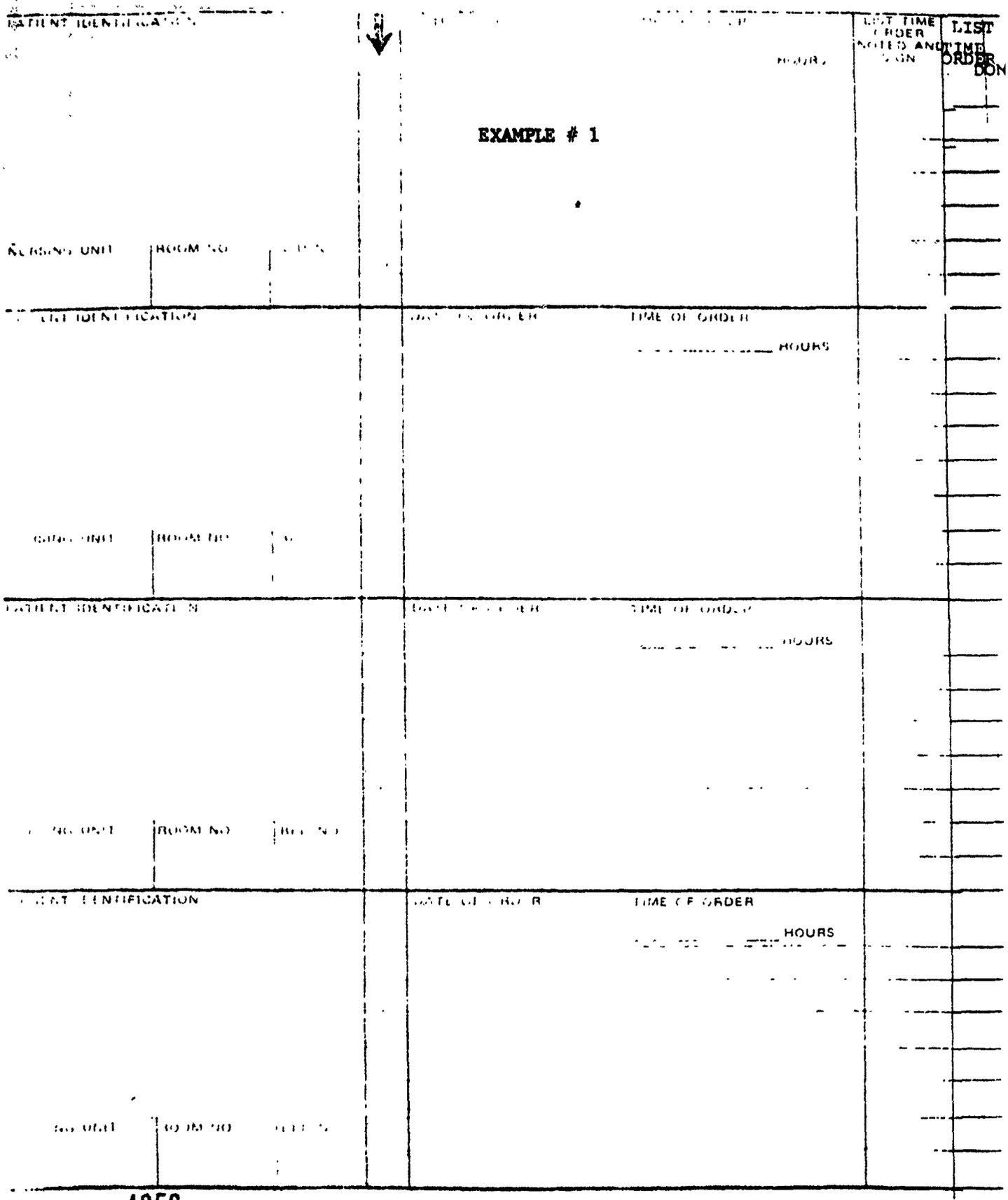
DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

D	7	8	9	10	11	12	13	14
E	15	16	17	18	19	20	21	22
N	23	24	01	02	03	04	05	06

DA FORM 1 FEB 79 4678 EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED.

EXAMPLE # 1



FORM 4256 APR 79

Incl 5

DA Form 4700 Supplemental Medical Data

Summary Sheet

All comments regarding DA 4700 mentioned its use, either for discharge planning or to document teaching needs and interventions. Common suggestions were for a standardized format for discharge planning which included the physician's plan, nursing preparation of the patient and any other referral or supporting agencies' plan for the patient's discharge. Such a standardized form would have multiple copies, one for in-patient record, out-patient record and for the patient, and would meet the needs of adult and pediatric patients in all services. Proper notation of this form would then eliminate a need for a discharge nurse note on SF 510.

If a DA 4700 form were used to indicate teaching requirements and interventions, such notations could then be eliminated from the 3888-1 and SF 510

Several Chief Nurses enclosed copies of overprints used at their facilities.

Many comments suggested streamlining the overprint approval process, perhaps having it at the local level.

DD Form 752 Intake and Output Worksheet

Summary Sheet

All comments regarding DD Form 752 addressed the desire to incorporate it into the permanent record rather than having it as a mere "worksheet." Again, this reflects one of the major themes of all responses received from the field: the redundancy in charting. Once placed on the I & O Sheet, the informations must be transferred to the SF 511 and, often, into the nursing notes.

> "DD Form 792 needs to be part of the permanent patient hospitalization record. This would save a tremendous amount of time for recopying all the information into the nurse's notes. The present way of recording I & O on SF 511 does not provide an adequate breakdown or space for breakdown. The word "worksheet" should be eliminated from the title of this form...." FT MEADE

Responses also suggested the DD Form 752 be designed to allow totaling of parameters at the end of each shift rather than every twenty-four hours. Additional space was requested for intravenous medications.

Finally, Letterman Army Medical Center made this suggestion:

> "Delete intake equivalent (lower right hand corner of DD Form 752. Either state only standard measurements, i.e., medicine cup, half pint, etc., or leave blank for local overprint.

SF 510 Nursing Notes
Summary Sheet

Few comments regarding the SF 510 Nursing Notes were directed at the structure of the form, for example:

"...eliminate AM/PM; change to 'time/date' in one column." (3 responses)

"...Change the (title of) 'Nursing Notes' to 'Nursing Progress Notes'."

"...the SF 510 is satisfactory in its present format."

Most comments were directed toward acts of recording nursing actions/observations and the problems therein. Comments fell into three main groups: the use of a Multidisciplinary Progress Note, the redundancy in charting, and format (SOAP, SOAPIE, SOAPIER, Narrative, etc.).

MULTIDISCIPLINARY NOTES

Seventy percent of all responses received from facilities worldwide addressed the use of a multidisciplinary progress note. The majority (66%) of total responses favored incorporating the nursing comments with the physician's progress note. The following are representative comments:

> "...(the problem is that) the progress of the patient's status is difficult to track. The physician, physician assistant, physical therapist, clinical dietitian, and respiratory therapist record on the progress notes. All nursing personnel record on the nursing notes...(it is recommended) that all patient progress be recorded on the progress notes. The documentation by all health care providers (should) jointly track progress, thereby reducing the current duplication of effort, and improve access to the written communication about patient status...." FT BENNING

> "I would combine nurse's notes and doctor's progress notes on one form. We are <u>the</u> only service that charts separately and if we all did chronological charting, the doctors would <u>read</u> our notes which would tend to make them credible and if we knew someone was reading them they would improve plus the doctors might learn something! It's symbiotic...." FT GORDON

If adopted, the title of the SF 509 (Doctor's Progress Notes) would require a change. Suggestions included "Patient's Progress Notes" or merely "Progress Note."

Several facilities expressed concern that there may be potential problems with the multidisciplinary note. The following is a summary of their points:

1. What format will be required? SOAP, a form of POMR, narrative descriptions, etc.? Confusion may arise if charting is done using different problem lists (i.e., the one specified by the physician vs. the problems defined on the nursing care plan).

2. Who would be authorized to chart? Currently, all nursing personnel, regardless of skill or educational level, are charting on the SF 510. Ideally, if written by a paraprofessional, notes are reviewed by the RN prior to writing on the permanent record. However, this is not always the case.

3. How much charting would be required, and by whom? This begins to address the redundancy issues. If a multidisciplined note is to eliminate some of the overlap of notes, must a cited physician concern still be addressed by the nurse if there is not additional information available? The opposite point can be taken as well. Will the nursing notes, often more detailed and charted with greater frequency, supplant the need for a daily MD note?

REDUNDANCY IN CHARTING

> "Charting needs to be made more efficient. Suits and evaluation for QA have necessitated complete documentation of nursing care. Since it is necessary, we need to make it as complete and yet as easy as possible...." FT EUSTIS

The above comment really sums up this section. Some information on every piece of nursing documentation in the system is repeated on a second, third or even fourth form. Much of this repeated information appears in the nurse's notes. Because Army regulations do not preclude repeated data (in fact, AR 40-407, para 2.8.C., cites information necessary for an admission note which duplicates that appearing on the DA 3888 and 3888-1) often the nursing personnel find they are charting "just to chart." The solution to the redundancy concern is seen to tie into the use of the DA Form 4677 and 4678. If performance and evaluation of nursing interventions could be annotated directly on sheets where nursing and medication orders are written, it was felt that the charting in a progress note would be decreased, and take on more meaning. Fifteen facilities referred to a form containing activities of daily living data. The MEDDAC at Panama provided an excellent example (Encl 1). It was suggested that if actions requiring documentation (i.e., those occurring within the normal course of hospitalization, e.g., diet, activity, vital sign frequency, etc.) were briefly annotated on such a data form the nursing note might reflect only a change, persistent information or an "event" which required elaboration; it would truly become a problem related note.

> "...(there is a problem with the nurse's notes)...Flow of documents is impractical and time consuming given current constraints of personnel...For ease of user and total patient care provided reference, all patient information should be in one location rather than the present minimum of two. Activities of daily living should be documented in check list form by the provided, i.e., 91B. SOAP problems should be recorded and progress notes written by professional staff...." FT DEVENS

> "...use the nurses notes as continuation sheet for any documentation which cannot be included on the activity flow sheet...." PANAMA

Similar suggestions were made for charting on the DA 4677 and 4678. Several suggestions were made to add a code symbol to reflect evaluation of nursing intervention on these forms:

> "The code would be as follows: '+' Satisfactory/within normal limits; '-' Unsatisfactory (must elaborate in the nurses notes); '0' Not observed/omitted (must comment in nurses notes)...." WRAMC (Encl 2)

> "A system is needed to quickly document reaction to routine medications. There are so many drugs for single patients, it is (a waste) ...of time and resources to require nurses to continuously document repetitive medication. A + or - system is suggested...A (+) indicates the medication, if given for pain, pain was relieved; if given for agitation, the patient is less agitated. A (-) indicates the given medication did not achieve the results for which it was given, i.e., if given for pain, the pain was not relieved; if given for agitation the patient is still agitated. This can be used for all controlled substances, be they routine, one time, or PRN orders. It can be used for PRNs other than controlled substances (i.e., MOM, Mylanta). When employed, the (-'s) have to be reflected in the nursing notes SF 510, the (+'s) do not...." WRAMC

The above would begin to address concerns such as:

> "...must every single dose of regularly scheduled narcotics (e.g., for terminal cancer patients -- not PRN meds) be charted on the SF 510? ...the medication is signed off on the sheet for each dose given...." FT HUACHUCA

> "...signing TDs to indicate that an order has been carried out is presently not enough documentation. If a patient has an order to ambulate and the patient does ambulate without problems, I think that initialing the TD without documenting this on the SF 510 is sufficient. I think that problems noted with ambulation should be documented. This also applies to nursing orders for observing post-op dressing. If the dressing is dry and intact, the TDs are initialed and this same information is presently expected in the nursing notes. Again, I think if the dressing is not dry and intact, this information and actions taken with evaluation should be documented on SF 510...pain medications (PRN) must be signed on the TD and in the nursing notes with evaluation. Again, I think with SOAPIE and SOAPIER charting that expected responses need not be documented on SF 510; but untoward reactions or no relief, etc., should be documented.... FT EUSTIS

Other examples of redundancy in information prompted comments such as:

> "...if we have to have a discharge form, why must we write it (the discharge information) on the care plan and again in the nursing note? One place or the other, please...!" FT EUSTIS

"...charting every shift on all category I and II patients is unreasonable, especially with long term patients experiencing no significant change in (their) status...(this) leads to redundancy and meaningless notes...." FT RILEY

"...if a nursing order indicates a task (to be performed) ...and is initialed on the green sheet each time (it is) performed, does this constitute a nursing note? If not...(there is) a log of redundancy in the nurse's notes...." FT EUSTIS

Comments regarding a charting format generally reflect a confusion as to what is the standard. Neither the ANC standards of nursing practice nor AR 40-407 specify a format. JCAH guidelines indicate that, "...nursing documentation should address the patient's needs, problems, capabilities, and limitations. Nursing intervention and patient response must be noted...." (P. 119 JCAH Manual, 1983.) Beyond this, there is no specification as to how to reflect the required information. Some comments include:

"...is SOAPIER charting mandated for all charting? If so, make standardized guidelines available...."

"...what kind do we use: SOAP/SOAPIER/SOAPIE/NARRATIVE...there is a need for the Corps to address (this)...mandate something...." FT BELVOIR

"...if it's SOAP, there is weakness. When a patient has multiple problems, nursing tends to chart only one problem...." (This was reiterated in six responses.)

"...dispense with narrative nursing notes -- require problem oriented charting, SOAPIER...." WRAMC

"Eliminate the expectation that an RN with 41 patients should write continuous, detailed notes on each patient with a SOAP format as if he/she were doing private duty and observing one patient. On certain patients, a summarized SOAP could be utilized. Individualized nursing care complicated short term surgical procedures, i.e., herniorraphy, a standardized SOP would probably suffice...." FT GORDON

"...look at what is done with the information, how it is used, identify its usefulness and whether it is a repetition of information gained elsewhere by others. The SOAPIER format and the nursing diagnoses need to be looked at long and hard as to its usefulness and impact on nursing care, especially in the form of chronic staffing shortages. The question is whether the current format is useful or an ivory tower dream for the ideal situation ...." FORT GORDON

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)

For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General

Mo. July Yr. 83

VERIFY BY INITIALING | INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 19	20	21	22	23	24
7/19	mc	Valium 5mg PO q 6°	06	mc	mc				
		"		+	+				
		"	12	mc	mc				
		"		+	+				
		"	18	mc	mc				
		"		+	-				
		"	24	mc	mc				
		"		-	+				
		"							

Explanation of (+) (-) method of documenting the effects of controlled substances

A. A (+) indicates the given medication achieved the results for which it was given.
   ie. if given for pain, pain was relieved
   ie. if given for agitation, the patient is less agitated

   A (-) indicates the given medication did not achieve the results for which it was given
   ie. if given for pain, and pain was not relieved.
   ie. if given for agitation, and patient is still as agitated

B. Can be used for all controlled substances, be they routine, one time, or PRN orders.

C. Can be used for PRNs other than controlled substances (ie MOM, Mylanta etc.)

D. When employed, the (-)'s have to be reflected in the nursing notes (SF 510), the (+)'s do not.

ALLERGIES ☐ YES ☐

PATIENT IDENTIFICATION

ADDITIONAL PAGES IN USE ☐ YES ☐ NO

ETC

USE PENCIL CIRCLE MED TIMES

D 7 8 9 10 11 12 13 14

E 15 16 17 18 19 20 21 22

N 23 24 01 02 03 04 05 06

DA FORM 1 FEB 79 4678

EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED

C-61

INCL-1

PATIENT ACTIVITY FLOW SHEET

DATE		* INDICATES PROBLEM FURTHER DOCUMENTED IN NURSING NOTES		
		NIGHT	DAY	EVENING
DIET	TYPE			
	AMOUNT EATEN			
HYGIENE	SELF-PARTIAL COMPLETE			
	ORAL CARE			
	BACK CARE			
	PERI CARE			
	FOOT CARE			
	REMOVE/REAPPLY ELASTIC STOCKINGS			
ACTIVITY	TYPE			
	TOLERATION			
	REPOSITIONED			
	RANGE OF MOTION			
SLEEP				
BOWEL/BLADDER ASSESSMENT	BOWEL SOUNDS			
	BOWEL MOVEMENTS			
	VOIDING			
	CATHETER			
I & O				

PATIENT IDENTIFICATION:	ALLERGIES: ☐ YES ☐ NO	PRIMARY DIAGNOSIS:
	Physician	Room Number/Bed

The idea that I'd like to submit, borrowed from Dr. Pardee, University of Washington, Seattle, would be to simply add a code symbol to reflect evaluation of nursing intervention on the green "TD" form. The code would be as follows:

+ satisfactory/within normal limits
- unsatisfactory (must elaborate in the nurses notes)
0 not observed/omitted (must comment in nurses note)

Please see the attached "TD" as an example.

(Worthy of consideration)

Nick 2

DA FORM 1 FEB 67 2496 REPLACES DD FORM 96, WHICH IS OBSOLETE.

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION) For use of this form, see AR 40-407. the proponent agency is the Office of The Surgeon General.	Mo. Dec. Yr. 83

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 1	2	3
1 Dec 83	mcc	VS q 4h c B/P	04	mcc +		
	-----		08	mcc +		
	-----		12	mcc		
	-----		16	(mcc)		
	-----		20	mcc +		
	-----		24	mcc +		
1 Dec 83	mcc (DO)	dipstick urines and guiac stools	08	mcc		
	-----		16	mcc		
	-----		24	(mcc)		

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:

ADDITIONAL PAGES IN USE. ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

+ satisfactory/within normal limits
- unsatisfactory
0 not observed/omitted

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

D 8 9 10 11 12 13 14 15

E 16 17 18 19 20 21 22 23

N 24 01 02 03 04 05 06 07

DA FORM 1 OCT 72 4677 EDITION OF 1 DEC 77 MAY BE USED.

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
~~Example~~	#1		VS q4h ± B/P: The nurse would note what was not WNL at 1200 (↑ fever) in the notes (24) and would also note why the 1600 VS were omitted (pt. off the ward for a procedure).
~~Example~~	#2		DS urine and guaic stool: A note must be made regarding what was not satisfactory or normal about the stool or urine (24 elevated urine glucose or guaic + stool). The 2400 readings omitted because, for example, no elimination or stool that shift.

POOR ORIGINAL

SOAPIE CHARTING METHOD

C-66

SF 511 Vital Signs Record
Summary Sheet

There were many comments regarding this standard form most of which reflected the need to provide additional space for recording a summary area for intake and output. Another suggested combining two parameters sheets (SF 511 and DD Form 752) to develop a flowsheet with applicability for any unit:

> "...There is a problem with the redundancy in the charting of patient vital parameters (i.e., vital signs, intake and output, neuro checks, etc.)...Suggest deleting the SF 511 and intake and output form. Develop a flowsheet that can be utilized on any nursing unit and could be kept as part of the permanent patient record. This new form should contain areas for vital signs, intake and output, physical assessment of vital parameters, etc., regardless of the change adopted. It is felt that BP's etc. do not need to be graphed, a task which is time consuming and could be inaccurate...." ISR

Flowsheets/Overprints
Summary Sheet

The pros and cons of more forms vs. less forms were voiced.

PRO/MORE

Numerous responses (N=15) recommend the development of standardized flowsheets for specialty areas, and some routine procedures:

AREAS	PROCEDURES
ICU	VS (post-op)
CCU	Neuro Checks
Post Anesthesia R.R.	Circulation Checks
Neonatal ICU	CPR

Common responses (n=15) from specialty areas emphasized the unsuitability of current forms for their areas. Recommend overprint assessment forms and history be developed for:

Pediatrics

OB

Psychiatry

Request local approval for overprints (n=6); one suggestion was for a "forum or central repository for all forms so an individual MTF could call upon these resources when the need arose and avoid duplication of effort."

Several responses included examples of flowsheets and overprints.

Comments from four MEDDACs sup up the above:

> "Specialty areas such as pediatrics, nursery, labor and delivery, and psychiatry often don't find forms suitable to their patient populations. Commonly used forms must have some capability or flexibility for incorporating these specialties. Could there be standard specialty 'version' of selected forms which use a suffix (e.g., 3888A) to denote the specialty? ...if the approach to forms for specialties is to leave room on forms for overprints, the approval process for overprints should be streamlined. Is it really necessary to require more than local approval for overprints?" FT CAMPBELL

> "In order to meet minimal standards in patient education and documentation requirements, this MEDDAC maintains 46 approved overprinted forms. It would be beneficial if there were a central clearing house that would maintain

copies of all the overprinted forms and would publish a list of available forms. Recommend that each Department of Nursing be given the authority to develop and approve any overprinted forms they feel necessary for patient teaching and documentation of care" FT LEONARD WOOD

"Every Army Hospital and each section within the hospital has developed their own 'checklist' or 'flow worksheets.' The Army needs a standard flowsheet to be a part of the permanent record and not a worksheet to be thrown out after the patient is discharged. Special areas such as MICU, NICU, SICU, CCU and RR need their own special flowsheets, but forms should be standard in all hospitals.... An additional flexible flowsheet could be developed for use as needed such as neuro checks, frequent vital signs, circulation checks, or make DA Form 3950 a variable flowsheet and have it become a part of the permanent record." FT MEADE

"We in the medical field (and certainly in nursing) are a specialized profession. To ask that one or a dozen forms ...fit the needs of post-partum or orthopedics, from neurosurgery to geriatrics, etc., is not feasible. I believe the time has come to fit the forms to the need, especially in terms of assessment and planning. Perhaps an overall general format, with content specific to the area, if need be, but certainly tailored to specific, special areas...." FT RILEY

"If the trend is to do more with less, overprints will continue to be a necessity. I feel that one set of information or forms Army-wide cannot be adapted to every set of circumstances and philosophies...." FT SILL

CON/LESS

Two excerpts succinctly address the concern of the opposing point of view regarding overprints:

"The proliferation of multiple new forms to improve the documentation has generally resulted in multiple sites for recording the same data, therefore, increasing the amount of documentation required. In general, the proliferated forms/overprints are not completed and therefore, hamper their effectiveness and increases liability as these forms, once approved, become our accepted level of practice." FT BENNING

"...the forms themselves encourage focus upon filling in the blanks and also encourage continued proliferation of even more DA 4700 overprints in the mistaken belief that the right forms will perfect nursing documentation." FT HUACHUCA

Miscellaneous Comments

Summary Sheet

The majority of the responses acknowledge an awareness that the basic components of the nursing process (nursing history and assessment, problem list/nursing diagnosis, nursing orders and documentation of the effect of the intervention) are here to stay. In addition, the aspects of assessing, planning and implementing are crucial to the way we as nurses "do business." At the same time, terms such as redundant, fragmented, time consuming, cumbersome and complex are used to describe the AMEDD nursing documentation structure. Some representative comments follow:

> "Standard Forms were developed at a time when unit management programs were planned for WRAMC...the administrative support originally planned to supplement the nurse's time spent with these inpatient records has not materialized (and probably never will)...." REDSTONE ARSENAL
>
> "...overall feelings are that the documentation process is satisfactory in present for it provides necessary informa tion for the nursing assessment. One of the problems, however, is the time involved in starting and keeping records current. High census and staff turnover make it very stressful for nurses to keep documentation current, adhering to the standards...." WILLIAM BEAUMONT
>
> "I find the current form of nursing documentation inadequate, cumbersome, and repetitious. It is extremely difficult to assess, plan and implement written documentation on patients since this requires at least 3 separate forms...During times of manpower shortage this crucial form of the nursing process goes undone because of the cumbersome process (also time consuming) of noting problems and outcomes on one sheet, inter ventions on another form. It would seem the old adage of 'to keep it simple' has certainly gone wanting in the current batch of nursing documentation forms...." FT RILEY
>
> "The following list of problem areas concerning inpatient nursing documentation is provided as requested:
>
> 1. Duplication of information.
>
> a. Admission vital signs are recorded four times.
> b. Discharge information is found on three forms.
> c. Admission nursing notes are written twice.
>
> 2. Time consumption and chance for error by transcripting all orders.

3. Time needed for complete documentation...." FT MEADE

"(Give us) anything (just) to prevent repeating (the) same (information) on forms...! "FT DIX
"I think that there are too many forms in use today on the wards. Studies should be made to determine if we are too busy repeating ourselves in documenting care, treatments, medications, and patient teaching. Possibly some of these forms can be eliminated or consolidated to afford us more time to spend with our patients rendering care for them. Documentation of care given is very important...but we don't need to continue to repeat ourselves...." FT DIX

"The standards of Nursing Practice as developed are a viable part of professional practice. The scope of the standards are comprehensive and...will fulfill the profession's obligation to assess, provide, evaluate and improve nursing practice. The current forms (DA Form 3888, 3888-1, 4677/78) are exceptional tools and with the suggested revisions will continue to improve the professional nurse's accountability and responsibility for nursing practice. The utilization of the progress notes for multi-disciplinary documentation along with the reduction of overprints/specialty forms will reduce our duplication of effort and improve our utilization of DA Forms...." FT BENNING

"Present documentation required is seen as necessary for 'legality' but also seen as taking the nurse away from the patient to perform large scale documentation ...the past system of documentation was favored over the present because it left more time for patient care...." WEST POINT

"Our concerns about current nursing documentation include:

1. The fact that data related to individual patients is fragmented and never conveniently available as a whole until after discharge.

2. The problem that no physician can ever know with any degree of certainty which of his many doctor's orders the nursing personnel consider to remain in effect. There is no written resource likely to be utilized by the physician to successfully determine the total current regime being practiced upon his patient...." FT HUACHUCA

"...the survey (one conducted by the NETs personnel at this facility) does suggest a degree of frustration in documenting the care given and the duplication of that care. There is a shift in attitude relative to view of self knowledge possessed

to use the nursing process and that on which such knowledge is documented. The views tend to be divergent and suggest that the forms given do not fit, i.e., the form dictates what should be done rather than thoughtful analysis utilizing the nursing process. To the extent these are out of alignment, then frustration increases. A degree of complexity exists about documenting patient care which conflicts with the demands of the work situation. There is no sense of 'do not document' at all. Rather, there is a sense of 'simplify the system' so that it fits...." FT GORDON

"In response to the question 'If I had the power to change the entire inpatient nursing documentation process, the thing I would do first would be to...The principle concerns are that the current system supports duplication for no purposes other than the form dictates that something needs to be written about (case given) in more than one place -- not that something does need to be written about or noted in more than one place. Related with this is a notion that one form be used for writing about patient care. There is also a sense that given diagnosis or problems ought to exist in a pre-printed format so that if the professional doing assessment recognizes the need to make it visible that this ought not to require writing it out, but retrieving it. Documentation ought to exist to reflect that outcome of an internal thinking process, not to take an internal process about what the patient needs and make it external...." FT GORDON (Incl 1 notes the response priority.)

Concern for the readiness mission of an ANC Officer and the problem of possibly encountering a completely different set of records in a TOE environment were expressed by such statements as:

"Why have a records system that will not be used in the field...?" FT RILEY

"Redesign should include applicability in the field environment...." FT CAMPBELL

Finally, from the educators' viewpoint, our process of implementing change and disseminating work of new requirements must be improved. In addition, a "from the top down" emphasis is critical for the success of any program:

"...General recommendations for nursing care plans and nursing documentation:

1. Develop teaching programs on nursing care planning (nursing process), and nursing documentation. The learning process must begin with the top executive and filter down to the lowest level that utilize the tools for direct patient care.

2. Establish a viable nursing audit/peer review system that requires participation of all the professional staff. Each professional nurse will assess compliance to establish standards on a minimum of one clinical record every month. This standards of nursing practice must be included in the performance standards of all professional personnel. Teaching/learning needs must then be met through on-going education programs...." FT BENNING

"During my last three years as a nurse educator, I worked very hard, long hours teaching the appropriate use of our documentation system. During that time, several items, which will come as no surprise, came to mind: the nursing process is documented in four or five separate areas, repetition is the rule and not the exception, and no two places within the Army System use the forms in anything resembling a similar manner...A full commitment to the use of the nursing process, nursing diagnosis, and nursing orders will be an absolute necessity in the future. Once commitment is made, nursing process must be documented easily and concisely in as few places as possible. This suggests using DA 4677/78 and Problem Oriented Nursing Record documentation...I believe increased emphasis must be placed on teaching nursing diagnosis in the basic orientation course as well as the nursing portion of the advanced course. Until such time as the Corps has a commitment to documenting nursing care in addition to the medical orders we follow, we will continue to experience gross difficulty validating what we do that is special and unique...." FRANKFURT

"...(all) will be to no avail if we do not change our methods of implementing change. I cannot recommend strongly enough the need to teach the teachers before they are expected to interpret regulations and sketchy guidance. Emphasis must be placed on bringing as many NETs personnel together as possible to learn the 'ideal' method. One alternative is to bring all MEDDAC NETs people together and then have them teach staff at their regional MEDDACs. Do not send them the information with no lesson outlines, guidance, or standardized approach...." FRANKFURT

APPENDIX A: If I had the power to change the entire inpatient nursing documentation process, the thing I would do first would be to:

Of the total 100 responses, 78 (78 per cent) of the population elected to write some answer to this fill-in item. Their answers were sometimes brief and sometimes long, but they frequently gave more than one answer. Their answers -- 96 -- are noted below. The principle concerns are that the current system supports duplication for no purpose other than the form dictates that something needs to be written about in more than one place -- not that something does need to be written about or noted in more than one place. Related with this is a notion that one form be used for writing about patient care. There is also a sense that given diagnosis or problems ought to exist in a pre-printed format so that if the professional doing the assessment recognizes the need to make it visible that this ought not to require writing it out, but retrieving it. Documentation ought to exist to reflect the outcome of an internal thinking process not to take an internal process about what the patient needs and make it external. Summary of this fill-in:

Excessive documentation of PRN Meds	4
Eliminate green sheet	5
Eliminate white sheet	5
Computerize it	7
Everyone use 509	11
Pre-printed NCP that could be individualized	4
Eliminate physical assessment	3
Use of flowsheet	5
Delete requirement for NCP on all patients	2
Go back to Cardex	2
Just use a problem list (without need to document everything that "proves" the existence of a problem)	4
Use narrative notes	4
Adequate staffing	3
Eliminate duplication	18
Use POMR Format	6
Redesign 3888 to combine admission and assessment form	7
Have patient check OFF comprehensive sheet of problem areas	1
Master problem list	2
Eliminate nursing care plan	3

APPENDIX D

Methodology Phase II

CNR STUDY WORKING GROUP

Office of the Inspector General, Headquarters, U.S. Army Health Services Command

LTC Beverly Greenly, AN, Inspector
MAJ Betty Ball, AN, Inspector

Nursing Division, Headquarters, U.S. Army Health Services Command

LTC Terris Kennedy, AN, Staff Officer

Nursing Science Division, U.S. Army Academy of Health Sciences

MAJ William Spring, AN, Inspector

Brooke Army Medical Center, For Sam Houston, Texas

MAJ Joanne Burton, AN, Clinical Head Nurse, Psychiatry
MAJ Shelby Christian, AN, Clinical Head Nurse, OB/GYN
MAJ Melissa Opio, AN, Clinical Head Nurse, Pediatrics
CPT Carolyn Adkins, AN, Quality Assurance Nurse Coordinator
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CPT Brenda Mygrant, AN, Clinical Staff Nurse, Intensive Care
1LT Gayle Dasher, AN, Clinical Staff Nurse, Medical/Surgical

CNR Study Advisors

Headquarters, U.S. Army Health Services Command

Clinical Services
Judge Advocate General
Patient Administration
Publications Directorate

U.S. Army Academy of Health Sciences

Unit Training Division

Headquarters, Department of the Army, Office of the Surgeon General

Clinical Policy Division
Publications Directorate

DEPARTMENT OF THE ARMY
US ARMY HEALTH CARE STUDIES AND CLINICAL INVESTIGATION ACTIVITY
FORT SAM HOUSTON, TEXAS 78234

MAY 25 1984

HSHN-H

SUBJECT: Clinical Nursing Records Study

Commander
Silas B. Hays US Army Community Hospital
Fort Ord, CA 93941

1. In recent years, much controversy has surfaced regarding all nursing documentation in US Army Treatment Facilities. General dissatisfaction with current documentation procedures has been verbalized within the Army Nurse Corps. The volume of requests for exception to policy and requests for overprints have demonstrated the magnitude of this concern. Pursuant to TSG FY 84 Army Medical Department Study Program, under AR 5-5, the Clinical Nursing Records Study will examine all inpatient nursing documentation required by the Army and the JCAH. The study proposes to determine inpatient nursing documentation needs and to field test the revised forms.

2. In order to insure validity of alternative documentation methods, it will be necessary to study facilities of various sizes and population served. Several MTFs are being contacted. Eight sites will be selected for final testing. Because of the size and locale of Silas B. Hays US Army Community Hospital, it has been recommended by HQ, HSC as one of the possible sites for data collection.

3. The study will entail a complete test of nursing documentation by removing selected DA and Standard Forms from facilities for a 90 day period, and substituting DA test forms. Audits of clinical records and the distribution of pre and post intervention satisfaction questionnaires will be integral parts of the study. A project officer within the Department of Nursing will be appointed to coordinate efforts at Silas B. Hays. This officer will be funded to come to Fort Sam Houston for one week of training, once test forms are approved.

4. Details of the study have been discussed with your Chief Nurse who has expressed interest in supporting this study. Definitive timetables are pending approval of test forms; however, local training would be coordinated by the project officer prior to actual data collection.

5. BG Connie Slewitzke, Chief, Army Nurse Corps, considers this study to be of high priority for the ANC. The proponent agency for the study is the US Army Health Care Studies and Clinical Investigation Activity. Colonel Marian Walls, ANC (HQ, HSC) is the Study Director. MAJ Martha Bell, ANC (HCSCIA) is the Principal Investigator and may be reached at AUTOVON 471-4880/ 4649 for further questions. LTC Terry R. Misener, ANC (HCSCIA), is Co-Investigator and may be reached at the same numbers if MAJ Bell is unavailable.

MAY 25 1984

HSHN-H
SUBJECT: Clinical Nursing Records Study

6. We would appreciate receiving your cooperation and command support for this high priority study. A timely response granting willingness to participate would be appreciated to formalize study plans. Final site selection will be communicated from this office.

Fred A. Cecere
FRED A. CECERE
LTC, MC
Commanding

HSXT-DN (25 May 84) 1st Ind
SUBJECT: Clinical Nursing Records Study

Headquarters, US Army Medical Department Activity (MEDDAC) Fort Ord, Fort Ord, California 93941 15 JUN 1984

TO: Commander, US Army Health Care Studies and Clinical Investigation Activity, ATTN: HSHN-H, Ft Sam Houston, Texas 78234

1. Reference letter dated 25 May 1984, subject as above.

2. Silas B. Hays Army Community Hospital supports Army research efforts. If selected as a data collection site for the Clinical Nursing Records Study, the research team will receive command support and full cooperation from the MEDDAC.

F. Quinones
F. QUINONES
COL, MC
Commanding

REQUESTED FACILITY INFORMATION

DEPARTMENT OF THE ARMY
US ARMY HEALTH CARE STUDIES AND CLINICAL INVESTIGATION ACTIVITY
Fort Sam Houston, Texas 78234

Clinical Nursing Records Study

Pre-side Selection Information

SITE:

PROJECT OFFICER: (AUTOVON):

CHIEF NURSE: (AUTOVON):

PRESENT BED CAPACITY: _____

CLINICAL NURSING UNITS (name, specialty & size, e.g., "Ward 1A, female medicine, 20 beds")

APPROXIMATE NUMBER OF HOSPITAL DISCHARGES PER MONTH: _____

APPROXIMATE MONTHLY USAGE OF:

DA Form 3888 _____ Standard Form 509 _____

3888-1 _____ 510 _____

4256 _____

4677 _____

4678 _____

4700 _____

QUALITY ASSURANCE INFORMATION: What is the mechanism used at your facility for performing "audits" of nursing records? (Who does them; how often; integrated committees, etc.) Please enclose copies of forms.

ARE ALL INPATIENT UNITS ON "UNIT DOSE?"

IF NO, which ones are NOT?

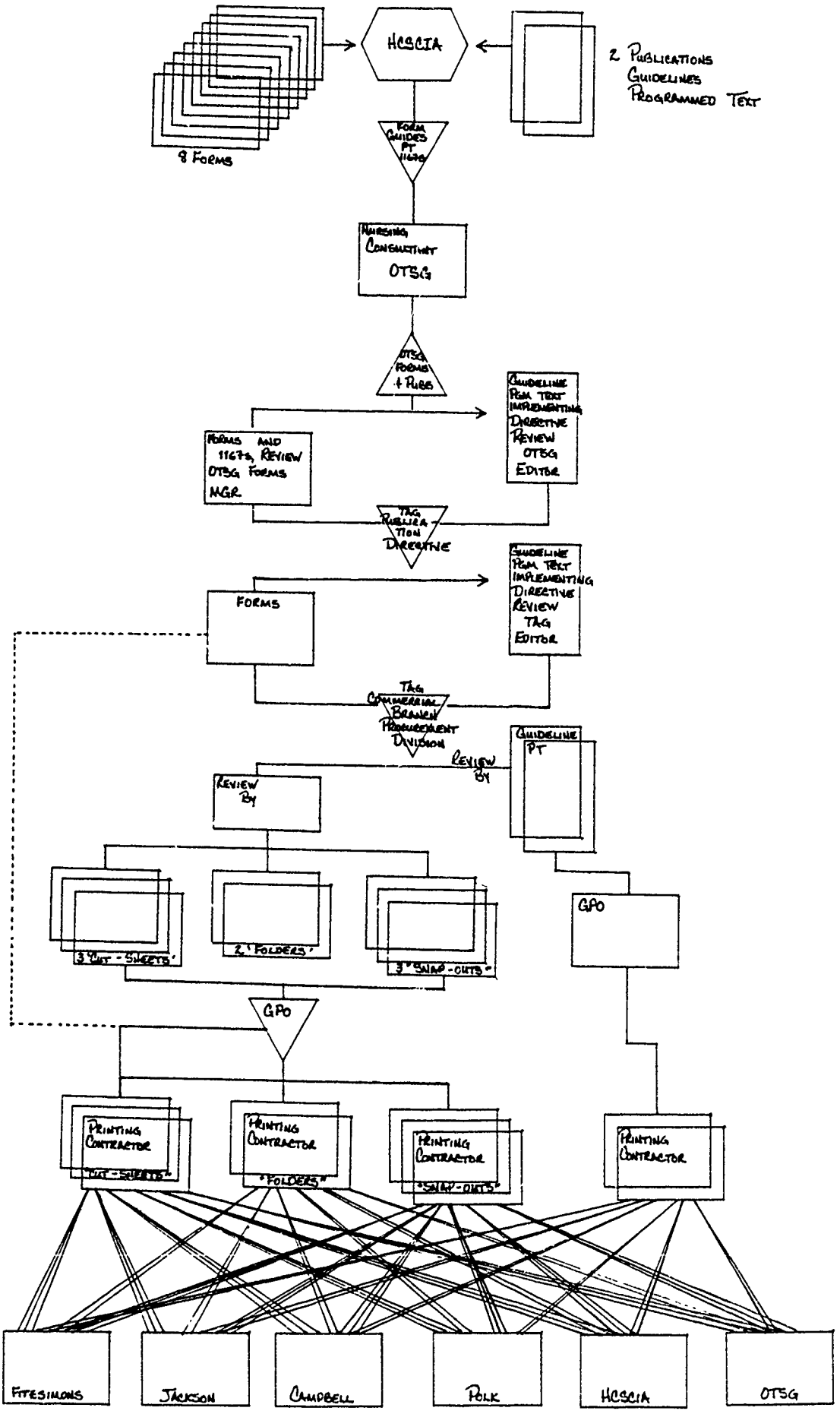
NURSING EDUCATION AND TRAINING SERVICE: Describe resources (e.g., Is the Chief, NETS "dual hatted"; capabilities to support DON wide education program; secretarial support, etc.)

SECRETARIAL RESOURCES AVAILABLE TO PROJECT OFFICER:

MISCELLANEOUS REMARKS:

Please attach copies of any modifications of DA Forms (DA approved or NOT!) used by nursing units at your facility. Include a cover sheet in the following format listing all overprinted forms:

CLINICAL AREA	MEDDAC/MEDCEN#	OVERPRINT ON	TITLE	DATED


HCSCIA
2 Publications
Guidelines
Programmed Text
8 Forms
Form Guides PT 1167s
Nursing Consultant OTSG
OTSG Forms + Pubs
Guideline Pgm Text Implementing Directive Review OTSG Editor
Forms and 1167s, Review OTSG Forms Mgr.
TAG Publication Directive
Guideline Pgm Text Implementing Directive Review TAG Editor
Forms
TAG Commercial Branch Procurement Division
Review By
Guideline PT
Review By
3" Mat - Sheets
2" Folders
3" Snap-Outs
GPO
GPO
Printing Contractor
Mat - Sheets
Printing Contractor
Folders
Printing Contractor
Snap-Outs
Printing Contractor
Fitzsimons
Jackson
Campbell
Polk
HCSCIA
OTSG

APPENDIX E

Findings Phase II

CNR Study Test Forms and Guidelines

MEDICAL RECORD - NURSING HISTORY AND ASSESSMENT

For use of this form, see HQDA Letter 40-85-4; the proponent agency is the Office of The Surgeon General.

Date and Time of Admission	Admission Diagnosis

	YES	NO	Patient's own words when possible
1. Tell me what you know about your illness/injury/ hospitalization.			
2. Do you have any other health problems?			
3. Have you been hospitalized before? If so, when and for what?			
4. What medications have you been taking? (to include prescription and over-the-counter drugs) For how long?			
5. Are you allergic to anything? If so, what? What reaction?			
6. Do you have any special needs that require assistance with daily activities? (e.g diet, eating, bathing, elimination, ambulating, sleeping; aides or prosthetic devices)			
7. What other concerns do you have?			
8. How can we be most helpful?			

Name of Local Contact/NOK	Relationship	Telephone Number

Interviewer's Signature, Rank & Title	Informant

Patient Identification

E-2

PERSONAL ARTICLES AND VALUABLES
(Indicate disposition of each item by Initials)

Item:	Bedside	Home	Treasurer	Other(Specify)

DA FORM 3888-2 (Test), Aug 85

(Continue on reverse)

MEDICAL RECORD–NURSING HISTORY AND ASSESSMENT

ADDITIONAL ASSESSMENT DATA

ADMISSION:	TPR	BP	WT	HT

E-3

Typed or Printed Name of RN	*Signature of RN and Date/Time*

ASSESSMENT CATEGORIES:

1. Growth and Development
2. Neurological
   a) Orientation
   b) Level of Consciousness; alert, drowsy, lethargic, comatose; Responses: to verbal and painful stimuli; Ability to follow commands; Reflexes
   c) Describe abnormalities
3. Eyes, Ears, Nose, and Throat
   a) Eyes: Pupils, vision
   b) Ears: Hearing, drainage
   c) Nose: Rhinorrhea, nasal surgery/trauma
   d) Throat: Sore, difficulty swallowing, appearance on inspection, lymph nodes
   e) Describe abnormalities
4. Cardiovascular
   a) Skin: Color, temp, turgor, moisture
   b) Peripheral Circulation: Pulses, edema, extremities
   c) IV's: Contents of bottle hanging, bottle number, condition of site
   d) Pain: Location, radiation, duration, type, relief
   e) Intrathoracic tubes and/or dressings
5. Pulmonary
   a) Respirations: Rate, regularity, effectiveness, depth, use of accessory muscles, nocturnal/expernal dyspnea. Chest movement associated with respirations
   b) Breath sounds: Clear to auscultation, Rales, Rhonchi, Wheezes, etc.
   c) Oxygen: Percent given, liters/min, method of administration, continuous or PRN
   d) Cough, sputum, suctioning
6. Gastrointestinal
   a) Abdominal: Auscultation (bowel sounds present), palpitation, abdominal girth measurement (if applicable)
   b) Dressings and/or drains
7. Genitourinary
   a) Urination: Continency, pattern change
   b) Female: Vaginal discharge, LMP, last PAP smear (if applicable), etc.
   c) Male: Abnormal discharge, swelling, pain
8. Integumentary
   a) Lesions, pressure points, contractures
   b) Color, moisture, edema, turgor, change in pigmentation
9. Musculoskeletal
   a) Movement: Purposeful/Non-purposeful, ROM, muscle strength, level of usual activity
   b) Foot care (as applicable), TED hose
10. Psycho-Social
    a) Adjustment to hospitalization and illness, manner, mood, behavior, relation to persons around them

REFERENCE: DA Pam 40-5
AMEDD Stds of Nursing Practice

Reverse of DA Form 3888 2 (Test), Aug 85

MEDICAL RECORD – NURSING HISTORY AND ASSESSMENT (continued)

For use of this form, see HQDA Letter 40-85-4; the proponent agency is the Office of The Surgeon General.

ADDITIONAL ASSESSMENT DATA

(Continue on reverse side)

PATIENT IDENTIFICATION

MEDICAL RECORD – NURSING HISTORY AND ASSESSMENT (continued)

For use of this form, see HQDA Letter 40-85-4; the proponent agency is the Office of The Surgeon General.

ADDITIONAL ASSESSMENT DATA

E-5

MEDICAL RECORD – NURSING CARE PLAN

For use of this form, see HQDA Letter 40-85-4; the proponent agency is the Office of The Surgeon General.

INSTRUCTIONS: Number and initial each recording.

Date Identified	Problems	Expected Outcomes (Goals)	Date Accomplished

PATIENT IDENTIFICATION:

(CONTINUE ON REVERSE)

MEDICAL RECORD – NURSING CARE PLAN (CONTINUED)

INSTRUCTIONS: Number and initial each recording. 2-3

Date Identified	Problems	Expected Outcomes (Goals)	Date Accomplished

Discharge Considerations:

NURSING DIAGNOSTIC CATEGORY GUIDELINES:

HEALTH PERCEPTION-MANAGEMENT PATTERN:
Health Management Deficit, Total
Health Management Deficit (Specify)
Infection, Potential for
Physical Injury, Potential for
Noncompliance (Specify)
Noncompliance, Potential (Specify)
Poisoning, Potential for
Suffocation, Potential for

NUTRITIONAL-METABOLIC PATTERN:
Decubitus Ulcer
Fluid Volume Deficit, Potential
Fluid Volume Deficit, (Actual)(1)
Fluid Volume Deficit, (Actual)(2)
Nutrition, Alteration in: Potential for More Than Body Requirements, or Potential Obesity; More Than Body Requirements, or Exogenous Obesity; Less Than Body Requirements, or Nutritional Deficit (Specify)
Skin Integrity, Potential Impairment of, or Potential Skin Breakdown
Skin Integrity, Impaired

ELIMINATION PATTERN:
Alteration in Bowel Elimination: Constipation or Intermittent Constipation Pattern
Alteration in Bowel Elimination: Diarrhea
Alteration in Bowel Elimination: Incontinence or Bowel Incontinence
Urinary Elimination Pattern, Altered
Urinary Elimination, Impairment of: Incontinence
Urinary Elimination, Impairment of: Retention
Stress Incontinence

ACTIVITY-EXERCISE PATTERN:
Activity Tolerance, Decreased (Specify Level)
Airway Clearance, Ineffective
Breathing Pattern, Ineffective
Cardiac Output, Alteration in: Decreased
Diversional Activity Deficit
Gas Exchange, Impaired
Home Maintenance Management, Impaired (Mild, Moderate, Severe, Potential, Chronic)
Joint Contractures, Potential
Mobility, Impaired Physical (Specify Level)
Self-Care Deficit, Total (Specify Level)
Self-Bathing-Hygiene Deficit (Specify Level)
Tissue Perfusion, Chronic Alteration in

COGNITIVE-PERCEPTUAL PATTERN:
Cognitive Impairment, Potential
Comfort, Alteration in: Pain
Pain Self-Management Deficit
Knowledge Deficit (Specify)
Sensory Deficit (Specify), Uncompensated
Sensory-Perceptual Alterations: Input Excess or Sensory Overload
Short-Term Memory Deficit, Uncompensated
Thought Processes, Impaired

SLEEP-REST PATTERN:
Sleep-Pattern Disturbance

SELF-PERCEPTION-SELF-CONCEPT PATTERN:
Anticipatory-Anxiety (Mild, Moderate, Severe)
Anxiety, Mild
Anxiety, Moderate
Anxiety, Severe (Panic)
Body Image Disturbance
Depression, Reactive (Situational)
Fear (Specify Focus)
Personal Identity Confusion
Self Esteem Disturbance

ROLE-RELATIONSHIP PATTERN:
Grieving, Anticipatory
Grieving, Dysfunctional
Independence-Dependence Conflict, Unresolved
Parenting, Alteration in
Parenting, Potential Alteration in
Social Isolation
Socialization, Alterations in
Translocation Syndrome
Verbal Communication, Impaired
Violence, Potential for

SEXUALITY-REPRODUCTIVE PATTERN:
Rape Trauma Syndrome
Rape Trauma Syndrome: Compound Reaction
Rape Trauma Syndrome: Silent Reaction
Sexual Dysfunction

COPING-STRESS TOLERANCE PATTERN:
Coping, Family: Potential for Growth
Coping, Ineffective Family: Disabling
Coping, Ineffective Family: Compromised
Coping, Ineffective (Individual)

VALUE-BELIEF PATTERN:
Spiritual Distress (Distress of Human Spirit)

REFERENCE:
Manual of Nursing Diagnosis, 1983
Marjory Gordon, McGraw Hill Pub. Co.
Reprinted by permission of McGraw Hill.

MEDICAL RECORD - NURSING DISCHARGE SUMMARY

For use of this form, see HQDA Letter 40-85-4, the proponent agency is the Office of The Surgeon General.

Date/Time:	Discharge to: ☐ Home Other (Specify)	Accompanied by:
	Mode: ☐ Ambulatory Other (Specify)	

I. ACTIVITY: ☐ No Restrictions Limitations (Specify) _____

_____ Patient and/or Significant Other (S.O.) communicates knowledge and understanding of activity limitations.

II. DIET ☐ No Dietary Restrictions If special, identify _____

_____ Patient/S.O. communicates understanding of dietary restrictions.

III. MEDICATIONS: ☐ No Medication Required

Name of Medication	Dosage	Frequency of Medication	Special Instructions

_____ Patient and/or Significant Other (S.O.) communicates knowledge and understanding of name, dosage, frequency and special instructions

IV. TREATMENTS/CARE:

Instructions Given	Patient/S.O Observed Demonstration (Date)	Patient/S O. Returned Demonstration (Date)

Equipment/Supplies (Specify)

V FOLLOWUP: You should be seen in _____ clinic in _____ (time period).

Important Telephone Numbers Emergency Room _____ Central Appointment _____ Ward _____ Clinic _____

Appointment ☐ No appointment needed

☐ An appointment is to be made by the patient at _____

☐ An appointment has been made at _____ clinic on _____ at _____ hours

☐ Referral Initiated

_____ Patient/S.O. communicates understanding of followup instructions.

VI. PATIENT'S CONDITION (Health Status relative to Nursing Care Plan): _____

Signature (Registered Nurse)	Additional Information:
Patient Identification:	

E-8

DA FORM 3888-5 (Test), Aug 85

COPY 1 - INPATIENT RECORD COPY

CLINICAL RECORD - DOCTOR'S ORDERS FOR MEDICATIONS

For use of this form, see HQDA LTR 40-85-4; the proponent agency is the Office of The Surgeon General

The doctor shall record date, time, and sign each set of orders. If problem-oriented medical record system indicate problem number.

MEDICATIONS ONLY

					INITIALS	
PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER ____ HOURS	Time Noted and Transcribed	Time Single Order Done
NURSING UNIT	ROOM NO.	BED NO.				
PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER ____ HOURS	Time Noted and Transcribed	Time Single Order Done
NURSING UNIT	ROOM NO.	BED NO.				
PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER ____ HOURS	Time Noted and Transcribed	Time Single Order Done
NURSING UNIT	ROOM NO.	BED NO.				
PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER ____ HOURS	Time Noted and Transcribed	Time Single Order Done
NURSING UNIT	ROOM NO.	BED NO.				

DA FORM 4256-1 (TEST), AUG 85 EDITION OF 1 JUL 77 IS OBSOLETE. **COPY 1 - INPATIENT**

CLINICAL RECORD - DOCTOR'S ORDERS FOR NON-MEDICATIONS

For use of this form, see HQDA LTR 40-85-4; the proponent agency is the Office of The Surgeon General

The doctor shall record date, time, and sign each set of orders. If problem-oriented medical record system indicate problem number. **NON-MEDICATIONS ONLY**				INITIALS	
PATIENT IDENTIFICATION			DATE OF ORDER TIME OF ORDER ________ HOURS	Time Noted and Transcribed	Time Single Order Done
NURSING UNIT	ROOM NO.	BED NO.			
PATIENT IDENTIFICATION			DATE OF ORDER TIME OF ORDER ________ HOURS	Time Noted and Transcribed	Time Single Order Done
NURSING UNIT	ROOM NO.	BED NO.			
PATIENT IDENTIFICATION			DATE OF ORDER TIME OF ORDER ________ HOURS	Time Noted and Transcribed	Time Single Order Done
NURSING UNIT	ROOM NO.	BED NO.			
PATIENT IDENTIFICATION			DATE OF ORDER TIME OF ORDER ________ HOURS	Time Noted and Transcribed	Time Single Order Done
NURSING UNIT	ROOM NO.	BED NO.			

DA FORM 4256-2 (TEST), AUG 85 EDITION OF 1 JUL 77 IS OBSOLETE. COPY 1 - INPATIENT

USE BALLPOINT PEN - PRESS FIRMLY - NO CARBON REQUIRED

Verify By Initialing		**THERAPEUTIC DOCUMENTATION CARE PLAN** *(NONMEDICATION)* For use of this form, see HQDA Letter 40-85-4; the proponent agency is the Office of The Surgeon General.		
ORDER DATE	CLERK/ NURSE	SINGLE ACTIONS, DELAYED ORDERS	TO BE DONE	COMPLETED
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ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:

PATIENT IDENTIFICATION:

CODES:

Initials only = Indicates completion of order
Initials and + = Satisfactory/within normal limits
*Initials and 0 = Unsatisfactory/Not observed/Omitted**

** See Nurse's note on SF 509*

CLINICAL RECORD		THERAPEUTIC DOCUMENTATION CARE PLAN (NONMEDICATION)																	
Verify By Initialing				*INITIAL PROPER COLUMN FOLLOWING COMPLETION*													
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(Continue on reverse)

THERAPEUTIC DOCUMENTATION CARE PLAN
(NONMEDICATION)

ERK/ RSE	PRN ACTION, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING COMPLETION* TIME/DATE/REASON/INITIALS/RESULTS CODE						

CODES: *Initials only* = *Indicates completion of order*
Initials and + = *Satisfactory/within normal limits*
Initials and 0 = *Unsatisfactory/Not observed/Omitted**

**See Nurse's note on SF 509*

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN
(NONMEDICATION)

Verify By Initialing

INITIAL PROPER COLUMN FOLLOWING COMPLETION

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☆ U.S. GOVERNMENT PRINTING OFFICE: 1985—482-768

Verify By Initialing		**THERAPEUTIC DOCUMENTATION CARE PLAN** *(MEDICATIONS)* For use of this form, see HQDA Letter 40-85-4; the proponent agency is the Office of The Surgeon General.		
ORDER DATE	CLERK/ NURSE	SINGLE ACTIONS, DELAYED ORDERS, PREOPERATIVES	TO BE GIVEN	DATE GIVEN/ TIME/INITIALS
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ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:

PATIENT IDENTIFICATION:

CODES:

Initials only = Indicates medication was administered
Initials and E = Effective
*Initials and I = Ineffective**
*Initials and Ø = Medication was not administered as ordered**

**See Nurse's note on SF 509*

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN
(MEDICATIONS)

Verify By Initic'ing

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

DATE DISPENSED

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR														
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THERAPEUTIC DOCUMENTATION CARE PLAN
(PRN MEDICATIONS)

ORDER/ EXPIR. DATE	CLERK/ NURSE	PRN MEDICATION, DOSE, ROUTE, FREQUENCY, REASON	*INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION* TIME/DATE/REASON/INITIALS/EFFECTIVENESS CODE						

CODES: *Initials only* = *Indicates medication was administered*
Initials and E = *Effective*
Initials and I = *Ineffective**
Initials and Ø = *Medication was not administered as ordered**

**See Nurse's note on SF 509*

CLINICAL RECORD				THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)													
Verify By Initialing				*INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION*													
				DATE DISPENSED													
ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR														
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DEPARTMENT OF THE ARMY
OFFICE OF THE ADJUTANT GENERAL
WASHINGTON, DC 20310-2100

REPLY TO ATTENTION OF

HQDA LTR 40-85-4

DASG-PSC-N (M) (20 May 85)

13 September 1985

Expires 13 September 1987

SUBJECT: Clinical Nursing Records Study—Test Forms

SEE DISTRIBUTION

1. References:

a. AR 40-407 (Nursing Records and Reports).

b. JCAH Standard III (Accreditation Manual for Hospitals—1984).

c. AR 5-5 (Army Studies and Analyses).

2. The Office of The Surgeon General (DASG-CN) is studying revised clinical forms for the documentation of nursing care in inpatient medical treatment facilities to assist in reducing redundancy and fragmentation of documentation in the clinical record. The test forms are:

a. DA Form 3888-2 (TEST) (Medical Record--Nursing History and Assessment).

b. DA Form 3888-3 (TEST) (Medical Record--Nursing History and Assessment (Continued)).

c. DA Form 3888-4 (TEST) (Medical Record--Nursing Care Plan).

d. DA Form 3888-5 (TEST) (Medical Record--Nursing Discharge Summary).

e. DA Form 4256-1 (TEST) (Clinical Record--Doctor's Orders for Medications).

f. DA Form 4256-2 (TEST) (Clinical Record--Doctor's Orders for Non-medications).

g. DA Form 4677-1 (TEST) (Clinical Record--Therapeutic Documentation Care Plan (Non-medication)).

h. DA Form 4678-1 (TEST) (Clinical Record--Therapeutic Documentation Care Plan (Medications)).

3. The forms will be field tested for 1 year at four MTFs:

a. Fitzsimmons Army Medical Center, Aurora, CO 80045-6000.

b. Bayne-Jones U.S. Army Community Hospital, Ft. Polk, LA 71459-6000.

c. Blanchfield U.S. Army Community Hospital, Ft. Campbell, KY 42223-1498.

d. Moncrief U.S. Army Community Hospital, Ft. Jackson, SC 29207-5700.

Based upon the evaluation data, recommendations for possible worldwide implementation of the form changes will be forwarded to HQDA(SGCP-CON-N), 5111 Leesburg Pike, Falls Church, VA 22041-3258.

4. A copy of the guidelines (encl 1) for form usage by personnel in test facilities is enclosed. A copy of a linear programmed instruction (encl 2) is also enclosed to aid the user of the guidelines.

5. A supply of the forms will be shipped direct to the test sites under separate cover.

6. Any questions about the forms should be addressed to COL Audre McLoughlin/COL Elizabeth Finn at AV 289-0143.

BY ORDER OF THE SECRETARY OF THE ARMY:

Donald J. DeLandro

DONALD J. DELANDRO
Brigadier General, USA
The Adjutant General

2 Encl

DISTRIBUTION:

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DEPARTMENT OF THE ARMY
OFFICE OF THE SURGEON GENERAL
WASHINGTON, DC 20310-2300

CLINICAL NURSING RECORDS STUDY--

FORM GUIDELINES 1 August 1985

Contents

List of Illustrations

List of Illustrations--Continued

List of Illustrations--Continued

SECTION I. INTRODUCTION

1. General information. a. Initiation of a permanent clinical record is an essential part of the inpatient admission procedure. Authorized clinical record forms for which nursing personnel are responsible or use frequently during the test period of the Clinical Nursing Records (CNR) Study are described in the following sections.

b. All entries on the forms will be made with a pen using reproducible black, or blue-black ink, except when otherwise specifically stated.

c. Erasures are prohibited. A line will be drawn through an incorrect entry and the initials of the person making the entry will be placed above the lined-out portion. The correct information or statement will be recorded following the lined out entry.

2. The nursing process. The nursing process is a systematic, problem solving thought process which is essential to accomplishing specific, predictable individualized care. This process consists of the following four elements:

a. Assessment/Appraisal: The nursing history gathers data from the patient, other informed persons, and documentation in the record. Once the nursing history is completed, a Registered Nurse (RN) will carry out the appropriate physical assessment necessary to initiate an individual plan of care. The nursing assessment must be accomplished by an RN so that all nursing care is professionally directed. This assessment phase of the nursing process will be completed within 24 hours of the patient's admission to the hospital.

b. Planning. The nursing care plan is developed from the initial and "on-going" assessment of the individual patient's needs. The care plan consists of a problem list, expected outcomes or goals, and discharge considerations to be accomplished by the nursing intervention. Planned nursing interventions are written as nursing orders.

(1) The nursing orders are a vital means of communicating nursing interventions to all care providers.

(2) The nursing orders are essential for accountability and responsibility in the documentation of care.

c. Implementation. This phase of the nursing process includes nursing actions determined by the nursing care plan. The delegation of nursing care to other care providers is the responsibility of the head nurse or designated charge nurse. The implementation phase concludes when the nurse's actions are completed and recorded. Therefore, the utilization of nursing orders and interventions will be documented on DA Form 4677-1 (TEST) (Clinical Record--Therapeutic Documentation Care Plan (Non-medication)) and DA Form 4678-1 (Test) (Clinical Record--Therapeutic Documentation Care Plan (Medications)).

d. Evaluation. This component is considered in terms of how the patient responded to the planned action. Evaluation of the effects of actions during and after the implementation phase determines the patient's response and the extent to which immediate, intermediate, and long-range goals are achieved. The evaluation phase, like the entire process, must be documented.

3. Nursing process documentation. a. The purposes of the US Army Medical Department (AMEDD) nursing documentation as a portion of the patient record are to--

(1) Serve as a communication tool, providing information for all care providers about the patient's clinical condition.

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

(3) Provide a basis for evaluation of care.

(4) Provide a basis for ensuring accountability.

(5) Serve as a legal document.

(6) Provide information for research and education.

(7) Serve as a tool to calculate patient acuity levels.

(8) Provide a record of quantifiable nursing activities for performance measurement and workload considerations.

b. The AMEDD nursing records complement each other so that when a clinical record is reviewed, the documentation will reflect the nursing process; i.e., assessment of the patient, planning, implementing, and evaluating the nursing care to meet the patient's individual needs. All forms must be completed. Forms which document the nursing plan consist of--

(1) A nursing history (interview) documented on DA Form 3888-2 (TEST) (Medical Record--Nursing History and Assessment).

(2) A nursing assessment documented on the reverse side of DA Form 3888-2 (TEST) with continuation on DA Form 3888-3 (TEST) (Medical Record--Nursing History and Assessment (Continued), as necessary.

(3) A nursing care plan documenting identified patient problems (or nursing diagnoses, as appropriate), discharge considerations, and goals on DA Form 3888-4 (Test) (Medical Record--Nursing Care Plan).

(4) Plans documented as nursing orders on DA Form 4677-1 (TEST) (Clinical Record--Therapeutic Documentation Care Plan (Non-medication)) and on DA Form 4678-1 (TEST) (Clinical Record--Therapeutic Documentation Care Plan (Medications)).

(5) Discharge preparations, documented as a nursing discharge summary on DA Form 3888-5 (TEST) (Medical Record--Nursing Discharge Summary).

(6) Evaluation of the patient's progress and effectiveness of nursing interventions as documented on SF 509 (Clinical Record--Progress Notes), DA 4677-1 (TEST), or DA 4678-1 (TEST).

SECTION II.

MEDICAL RECORD--NURSING HISTORY AND ASSESSMENT, DA FORM 3888-2 (TEST) AND MEDICAL RECORD--NURSING HISTORY AND ASSESSMENT--CONTINUATION, DA FORM 3888-3 (TEST)

4. Purpose. DA Form 3888-2 (TEST) and DA Form 3888-3 (TEST) document a baseline nursing history and assessment on each patient. Ideally, the nursing history and assessment will be completed upon admission to the medical treatment facility (MTF). They will serve as the admission nursing note if completed at that point. If not completed at admission, a nursing admission note must be written in the SF 509 progress notes. The nursing history is obtained by the nursing personnel. The nursing assessment is completed and recorded by an RN within 24 hours of admission. All forms are a permanent part of the patient's clinical record. Currently approved overprints used as guides for the nursing history and assessment may be reprinted on the test forms during the course of the CNR study. Information recorded on the test form should not be duplicated on the overprint.

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

6. Content. a. DA Form 3888-2 (TEST). Data entered on this form represents baseline health status information needed by the nurse to plan care. The information may be obtained from the patient, other informed persons, and the patient's records.

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

MEDICAL RECORD - NURSING HISTORY AND ASSESSMENT

For use of this form, see DA Ltr 40-85- , the proponent agency is the Office of the Surgeon General.

Date and Time of Admission	Admission Diagnosis
27 June 83 1900	Diabetes Mellitus

	YES	NO	Patient's own words when possible
1. Tell me what you know about your illness/injury/ hospitalization.			"I have alot of sugar and take pills and shots. I've been losing so much weight and go to the bathroom all the time." S/
2. Do you have any other health problems?		✓	Patient responds "No" However, daughter indicates frequent episodes of confusion, inability to move from bed to chair; bed sores
3. Have you been hospitalized before? If so, when and for what?	✓		S/ Frequently: 6x past 8 mos for same dx
4. What medications have you been taking? (to include prescription and over-the-counter drugs) For how long?			S/ Lente Insulin 20u qd
5. Are you allergic to anything? If so, what? What reaction?		✓	
6. Do you have any special needs that require assistance with daily activities? (e.g. diet, eating, bathing, elimination, ambulating, sleeping; aides or prosthetic devices)	✓		Help to get OOB, walking; uses walker; help w all ADLs; Soft diet - upper dentures - no lower teeth or dentures
7. What other concerns do you have?			Daughter relates: "Has the best home but admits she doesn't understand diabetes very well.
8. How can we be most helpful?			S/ "Let me alone!"

Name of Local Contact/NOK	Relationship	Telephone Number
Elizabeth Caudle	daughter	123-4567

Interviewer's Signature, Rank & Title	Informant
James Smith 1LT ANC	patient & daughter

Patient Identification

DATA FROM ID PLATE

PERSONAL ARTICLES AND VALUABLES
(Indicate disposition of each item by initials)

Item	Bedside	Home	Treasurer	Other (Specify)
eyeglasses	JS			
dentures	JS			
$10 CASH				to daughter

DA FORM 3888-2 (TEST) (Continue on reverse)

Figure 1. Example of a nursing history (front side of DA Form 3888-2 (TEST))

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

(b) Responses by the patient to the interview questions may be recorded next to the questions in the provided area.

(c) If additional space is required, the history may be continued on DA Form 3888-3 (TEST).

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

(e) The person collecting the data is to sign his or her name, rank, and title, and list from whom the data was obtained in the Informant block (e.g., "patient," mother--Mrs. Jones," etc).

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

(g) The nursing history is obtained by the nursing personnel.

(2) The reverse side of DA Form 3888-2 (TEST) provides an area for additional assessment data. (See figs 2 and 3.)

(a) The nursing assessment is completed and recorded by an RN within 24 hours of admission. If recorded at admission, it will serve as the admission nursing note. The time and date the assessment is made is recorded in the space provided.

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

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

(d) DA Form 3888-3 (TEST) may be used as necessary. (See b below.)

(e) The nursing assessment is reviewed, and updated as additional data are collected and patient needs and potentials change.

(3) The RN may use multiple modalities to collect patient data from which a plan of care is developed. However, regardless of what data is collected, and by whom, the RN is ultimately charged with the responsibility to ensure validity and reliability of the collected data.

MEDICAL RECORD--NURSING HISTORY AND ASSESSMENT

ADDITIONAL ASSESSMENT DATA

ADMISSION: TPR 102-100-36 BP 200/100 WT 256 lbs HT 66"

DATE/TIME:

27 June 83 1930.

In accordance with the Army Medical Department Standards of Nursing Practice (DA Pam 40-5):

A nursing assessment includes a minimal statement on General Appearance, Age, Sex, Race, Height, Weight, Physical Disabilities, as applicable, Condition of the Skin, Behavior indicative of mental-emotional status.

Data on the biophysical status, in the categories listed below, as appropriate for planning care, is also included in the admission assessment. "Appropriate" is the key word. Each category does not have to be addressed if it is not adding information necessary to provide nursing care.

Signature (Registered Nurse)

James Smith LCPL

ASSESSMENT CATEGORIES:

1. Growth and Development
2. Neurological
   a) Orientation
   b) Level of Consciousness: alert, drowsy, lethargic, comatose; Responses: to verbal and painful stimuli; Ability to follow commands; Reflexes
   c) Describe abnormalities
3. Eyes, Ears, Nose, and Throat
   a) Eyes: Pupils, vision
   b) Ears: Hearing, drainage
   c) Nose: Rhinorrhea, nasal surgery/trauma
   d) Throat: Sore, difficulty swallowing, appearance on inspection, lymph nodes
   e) Describe abnormalities
4. Cardiovascular
   a) Skin: Color, temp, turgor, moisture
   b) Peripheral Circulation: Pulses, edema, extremities
   c) IV's: Contents of bottle hanging, bottle number, condition of site
   d) Pain: Location, radiation, duration, type, relief
   e) Intrathoracic tubes and/or dressings
5. Pulmonary
   a) Respirations: Rate, regularity, effectiveness, depth, use of accessory muscles, nocturnal/exertional dyspnea. Chest movement associated with respirations
   b) Breath sounds: Clear to auscultation, Rales, Rhonchi, Wheezes, etc.
   c) Oxygen: Percent given, liters/min, method of administration, continuous or PRN
   d) Cough, sputum, suctioning
6. Gastrointestinal
   a) Abdominal: Auscultation (bowel sounds present), palpation, abdominal girth measurement (if applicable)
   b) Dressings and/or drains
7. Genitourinary
   a) Urination: Continency, pattern change
   b) Female: Vaginal discharge, LMP, last PAP smear (if applicable), etc.
   c) Male: Abnormal discharge, swelling, pain
8. Integumentary
   a) Lesions, pressure points, contractures
   b) Color, moisture, edema, turgor, change in pigmentation
9. Musculoskeletal
   a) Movement: Purposeful/Non-purposeful, ROM, muscle strength, level of usual activity
   b) Foot care (as applicable), TED hose
10. Psycho-Social
   a) Adjustment to hospitalization and illness, manner, mood, behavior, relation to persons around them

REFERENCE: DA Pam 40-5
AMEDD Stds of Nursing Practice

DA FORM 3888-2 (TEST) (Reverse)

Figure 2. Example 1 of additional nursing history (Additional Assessment Data) for DA Form 3888-2 (TEST)

MEDICAL RECORD—NURSING HISTORY AND ASSESSMENT

ADDITIONAL ASSESSMENT DATA

ADMISSION: TPR 102-88-36 BP 200/100 WT 256 Lbs HT 66"

DATE/TIME:

27 Jan 83 1530

84yo white female admitted wea w/c with medical dx diabetes mellitus x15 years. Recently on insulin (as specified in history). Hx. polyuria, polydipsia, anorexia, ~20 lb wt loss in last 6 mos. 6 previous admissions for same in past 3 mos.

Appears alert, answers questions appropriately, but daughter states patient seems confused, disoriented and wanders frequently at night.

Physical assmnt shows a debilitated, emaciated, dehydrated patient with decubiti on ⓞ buttock 4x3cm, Sacral decubiti 5x11cm, both draining purulent material. Ankle bones & heels reddened. Gait unsteady when walking with assistance from nurse. Pt admits periods of dizziness and has fallen at home x2. Skin turgor poor, eyes sunken, mucous membranes dry. Ecchymosis on ⓡ hip and elbows

Signature (Registered Nurse)

Jane Smith LCT BMC

ASSESSMENT CATEGORIES:

1. Growth and Development
2. Neurological
   a) Orientation
   b) Level of Consciousness: alert, drowsy, lethargic, comatose; Responses to verbal and painful stimuli; Ability to follow commands; Reflexes
   c) Describe abnormalities
3. Eyes, Ears, Nose, and Throat
   a) Eyes: Pupils, vision
   b) Ears: Hearing, drainage
   c) Nose: Rhinorrhea, nasal surgery/trauma
   d) Throat: Sore, difficulty swallowing, abnormalities on inspection, tympanic membrane
   e) Describe abnormalities
4. Cardiovascular
   a) Skin: Color, temp, turgor, moisture
   b) Peripheral Circulation: Pulses, edema, extremities
   c) IV's: Contents of bottle hanging, bottle number, condition of site
   d) Pain: Location, radiation, duration, type, relief
   e) Intracardiac lines and/or dressings
5. Pulmonary
   a) Respirations: Rate, regularity, effort involved, depth, use of accessory muscles, dyspnea/abnormal dyspnea, Chest movement associated with respirations
   b) Breath sounds: Clear to auscultation, Rales, Rhonchi, Wheezes, etc.
   c) Oxygen: Percent given, liters/min, method of administration, continuous or PRN
   d) Cough, sputum, suctioning
6. Gastrointestinal
   a) Abdominal: Auscultation (bowel sounds present), palpation, abdominal girth measurement (if applicable)
   b) Cravings and/or drains
7. Genitourinary
   a) Urination: Continency, Reclam change
   b) Female: Vaginal discharge, LMP, last PAP smear (if applicable), etc.
   c) Male: Abnormal discharge, hernias, pain
8. Integumentary
   a) Lesions, pressure points, temperature
   b) Color, moisture, edema, turgor, change in pigmentation
9. Musculoskeletal
   a) Movement: Purposeful/non-purposeful, ROM, muscle strength, level of self activity
   b) Foot care (as applicable), TED hose
10. Psycho-Social
   a) Adjustment to hospitalization and illness, manner, mood, behavior, relation to persons around them

REFERENCE: DA Pam 40-3
AMEDD Stds of Nursing Practice

DA FORM 3888-2 (TEST) (Reverse)

Figure 3. Example 2 of additonal nursing history (Additional Assessment Data) for DA Form 3888-2 (TEST)

b. DA Form 3888-3 (TEST). This form provides space for the continuation of data collected during either the nursing history or the nursing assessment. Date and time of continuation entry will be made prior to the beginning of the notation. When used, the recorder will place signature, rank, and title at the end of the entry. (See fig 4.)

MEDICAL RECORD – NURSING HISTORY AND ASSESSMENT (continued)

For use of this form, see DA Ltr 40-85- , the proponent agency is the Office of The Surgeon General.

ADDITIONAL ASSESSMENT DATA

1 April 1984 0800.

This space can be used as necessary, to continue recording the nursing history, or assessment information. If completed at the time of admission, the documentation suffices for the admission nursing note. The entry will end with the name, rank and title of the recorder. Multiple DA forms 3888-3 (TEST) may be used to record extensive information. ———

——————— John Smith, RN, DAC

(Continue on reverse side)

PATIENT IDENTIFICATION

DATA FROM ID PLATE

DA Form 3888-3 (TEST)

Figure 4. Example of nursing history continuation for DA Form 3888-3 (TEST)

SECTION III. MEDICAL RECORD--NURSING CARE PLAN, DA FORM 3888-4 (TEST)

7. Purpose. DA Form 3888-4 (TEST) is used to document the identified nursing care problems, discharge considerations and goals derived from the problems, reflective of the prognosis. Although all persons involved in the patient's care will contribute to the development of the care plan, the RN is responsible for its preparation. It is used by all nursing personnel involved in the care of the patient. The nursing care plan is a permanent part of the patient's clinical record. Currently approved overprints may be reprinted on the test form during the course of the CNR Study.

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

9. Content. a. The nursing care plan will reflect current standards of nursing practice, and measures which will facilitate the prescribed medical care to restore, maintain, and promote the patient's well being. It is used in conjunction with DA Forms 4677-1 (TEST) and 4678-1 (TEST) which list the nursing actions and other prescribed orders related to achieving the specified goals.

b. The date nursing and/or patient problems are identified is to be entered in the column provided. (See fig 5.)

MEDICAL RECORD — NURSING CARE PLAN

For use of this form, see DA Ltr 40-EG ; the proponent agency is the Office of The Surgeon General.

INSTRUCTIONS: Number and initial each recordent.

Date Identified	Problems	Expected Outcomes (Goals) *	Date Accomplished
23 June 83			

Figure 5. Example of a Date Identified entry for a nursing problem on DA Form 3888-4 (TEST)

c. Problems are to be listed in the appropriate column. Nursing diagnoses (terms used to summarize assessment data) describe the patient's actual or potential health problems. They represent clinical judgements made by the RN and are conditions primarily resolved by nursing care methods. When appropriate, nursing diagnoses may be listed in lieu of patient problems. Categories and diagnoses listed on the form are merely guides. As patient problems (or nursing diagnoses) are identified, they are recorded in the appropriate column, and numbered in sequence of identification. Problems are prioritized, reviewed and revised by the RN to meet the changing need of the patient. Corresponding nursing interventions written as nursing actions or orders on the DA Forms 4677-1 (TEST) and 4678-1 (TEST) will subsequently reflect the number(s) of the identified problem(s) and nursing diagnosis(es). (See figs 6 and 7.)

MEDICAL RECORD — NURSING CARE PLAN

For use of this form, see DA Ltr 40-85- , the proponent agency is the Office of The Surgeon General.

INSTRUCTIONS: Number and initial each recording.

Date Identified	Problems	Expected Outcomes (Goals)	Date Accomplished
29 June 85	#1 Pt and daughter don't understand how to give insulin IM	Pt + dau will demonstrate appropriate technique of giving insulin before discharge	

Figure 6. Example of a nursing care plan (specifiying "Problems") for DA Form 3888-4 (TEST)

MEDICAL RECORD — NURSING CARE PLAN

For use of this form, see DA Ltr 40-85- , the proponent agency is the Office of The Surgeon General.

INSTRUCTIONS: Number and initial each recording.

Date Identified	Problems	Expected Outcomes (Goals)	Date Accomplished
29 June	#1 Knowledge deficit: insulin administration (Pt + daughter)	Pt + daughter will demonstrate appropriate technique of insulin admin before pt discharge.	

Figure 7. Example of a nursing care plan (use of nursing diagnosis) for DA Form 3888-4 (TEST)

d. Expected Outcomes (Goals) based upon the problems listed in the preceeding column on the form will be specified. These goals (the desired results of planned nursing interventions) should be mutually set with the patient and/or family. Based on the nursing assessment, they will be realistic, measurable, and consistent with the therapy prescribed by the responsible medical practitioner. When a problem no longer exists, and the goal was accomplished or revised, the date the goal was accomplished will be entered in the proper column. Corresponding nursing orders on the therapeutic documentation care plans will be discontinued.

e. In those isolated instances when there are no problems to be addressed on admission, the RN will document such on the care plan. Each patient's status will be reassessed at least every 24 hours. If there is no further change, it is necessary to document that a periodic assessment was done and that the status remains unchanged. The reassessment of the patient may be noted as a

nursing order for those who have no identified problems specified on admission. The reassessment and subsequent findings may be documented directly on the care plan or in the nursing progress notes. (See fig 8.)

MEDICAL RECORD – NURSING CARE PLAN

For use of this form, see DA Ltr 40-85- ; the proponent agency is the Office of The Surgeon General.

INSTRUCTIONS: Number and initial each recording.

Date Identified	Problems	Expected Outcomes (Goals)	Date Accomplished
27 June	Patient admitted to Ward - no identified problems on		
	admission. Leaves in 24 hours after Notes		
	Completed. LL RN DAC		

Figure 8. Example of a nursing care plan (no identified problems on admission) for DA Form 3888-4 (TEST)

f. Early discharge planning is essential. Nursing is in a unique position to identify a variety of patient needs, ranging from special concerns for small children to simple or elaborate rehabilitation needs. Nursing staff should be alert to the need for early referrals to appropriate groups. Discharge planning begins at admission with the assessment by the RN. Any discharge considerations, identified at admission and throughout hospitalization, are noted in the space provided on the reverse side of DA Form 3888-4 (TEST). (See fig 9.)

MEDICAL RECORD – NURSING CARE PLAN (CONTINUED)

For use of this form, see DA Ltr 40-85- ; the proponent agency is the Office of The Surgeon General.

INSTRUCTIONS: Number and initial each recording.

Date Identified	Problems	Expected Outcomes (Goals)	Date Accomplished

Discharge Considerations: Family unaware of proper diabetic care - need to include 27 June 83. Family meeting. RN + Dietitian visit in small apt; has diabetic; problem getting diet to shops for meals; will need Community Health referral. MS

Figure 9. Example of a nursing care plan (discharge considerations) for DA Form 3888-4 (TEST)

SECTION IV.

CLINICAL RECORD--DOCTOR'S ORDERS FOR MEDICATIONS, DA FORM 4256-1 (TEST) AND CLINICAL RECORD--DOCTOR'S ORDERS FOR NON-MEDICATIONS, DA FORM 4256-2 (TEST)

10. Purpose. DA Form 4256-1 (TEST) is utilized for medication orders only; this is inclusive for administration of medications in any form: intravenous, oral, intramuscular, inhalation, or topical. DA Form 4256-2 (TEST) is utilized for non-medication orders only. Currently approved overprints of medication and non-medication standing orders may be reprinted on respective test forms during the course of the CNR Study.

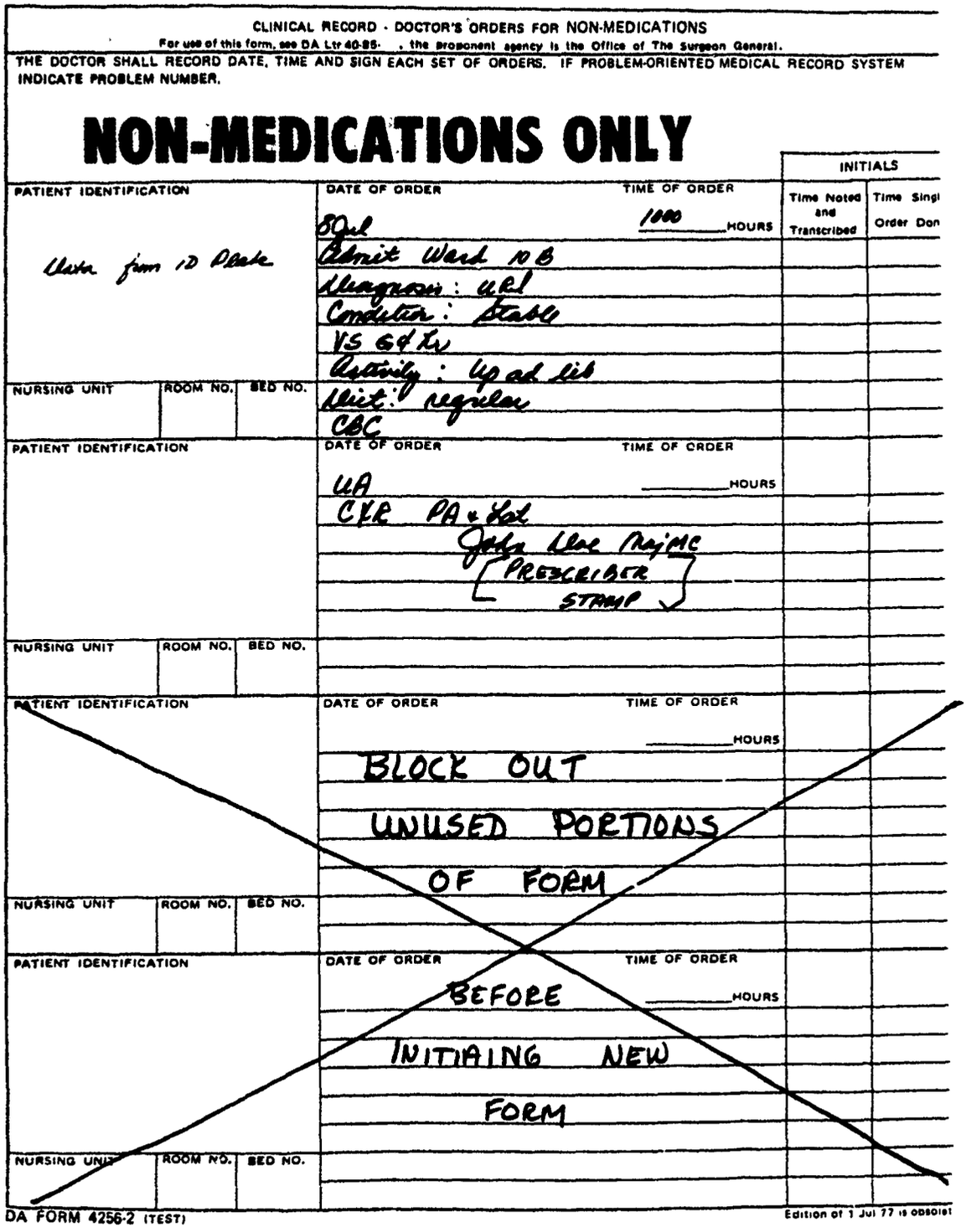
11. Disposition and use. DA Forms 4256-1 (TEST) and 4256-2 (TEST) are three-part carbonless forms, maintained in the patient's chart. The original copy of each form remains with the permanent record. The second copy (pink) is sent to the pharmacy. The pharmacy is to receive a copy of all orders. The ward copy (buff) is used to communicate orders to the nursing staff. It may be used as a medication or treatment reminder and discarded when no longer required.

12. Preparation. Enter all patient identification on each form as directed by AR 40-66. Addressograph plates should be used in each part marked Patient Identification. The portion indicating Nursing Unit, Room Number, and Bed No. may be utilized as appropriate.

13. Method of writing orders. The prescriber will record the date and time the order is written as indicated on each form. More than one order may be written in each section of the forms, but no more than one order may be written on a single line. Use of the entry "routine orders" (to imply a number of predetermined orders) is prohibited. A group of orders written at one time for the same patient requires only one signature and one date entry per sheet. Standing orders which are overprinted on the forms must be signed by the prescriber. Nonapplicable standing orders will be lined out and initialed by the physician initiating the standing orders. When additional sheets are required for continuation of a group of orders written at one time, each sheet will reflect both a date entry and a signature. All prescribers' signatures must have the prescriber's identification stamp. Orders should be written sequentially or unused portions of the order sheets blocked out if a new form is initiated. (See fig 10.)

14. Method of accounting for orders. a. Written orders will be accounted for in the far right column titled Time Noted and Transcribed. Department of nursing personnel trained in transcription of orders, who note two or more orders, may enclose the orders in a bracket, list the time orders are noted, and sign or initial his or her name. These notations imply that the order has been transcribed to DA Form 4677-1 (TEST), or DA Form 4678-1 (TEST).

b. Single action order. A single action order is a one-time order which is completed within the responsible RN's tour of duty. It requires no further nursing action once completed and will be signed off as having been completed in the extreme right column titled Time Single Order Done. The time and signature or initial of the individual carrying out the order indicates that the order has



CLINICAL RECORD - DOCTOR'S ORDERS FOR NON-MEDICATIONS

For use of this form, see DA Ltr 40-85- , the proponent agency is the Office of The Surgeon General.

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM-ORIENTED MEDICAL RECORD SYSTEM INDICATE PROBLEM NUMBER.

NON-MEDICATIONS ONLY

INITIALS

PATIENT IDENTIFICATION

Usta from ID Clerk

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER

8 Jul 1000 HOURS

Admit Ward 10B
Diagnosis: URI
Condition: Stable
VS 6 & Lv
Activity: Up ad lib
Diet: regular
CBC

Time Noted and Transcribed | Time Signi Order Don

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER

UA
CXR PA & Lat
John Doe MD/MC
[PRESCRIBER STAMP]

HOURS

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER

BLOCK OUT UNUSED PORTIONS OF FORM

HOURS

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER

BEFORE INITIAING NEW FORM

HOURS

DA FORM 4256-2 (TEST)

Edition of 1 Jul 77 is obsolet

Figure 10. Example of writing of orders for DA Form 4256-2 (TEST)

been completed and requires no transcription to the DA Form 4677-1 (TEST) or DA Form 4678-1 (TEST). Some single action orders (e.g., medications or procedures) will require an assessment of the efficacy of the intervention. If such an order has not been transcribed to the DA 4677-1 (TEST) or DA 4678-1 (TEST), the assessment must appear in the progress notes. Results codes (see paras 18 and 26) appearing on the DA 4677-1 (TEST) or DA 4678-1 (TEST) are not authorized for use on the DA 4256-1 (TEST) or DA 4256-2 (TEST). If the single action order is not completed within the responsible RN's tour of duty, the order becomes a delayed order and will be transcribed (rewritten) to the appropriate therapeutic documentation care plan. Completed single action orders and all STAT orders must be individually accounted for (may not bracket). (See fig 11.)

CLINICAL RECORD - DOCTOR'S ORDERS FOR NON-MEDICATIONS

For use of this form, see DA Ltr 40-85- , the proponent agency is the Office of The Surgeon General.

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM-ORIENTED MEDICAL RECORD SYSTEM INDICATE PROBLEM NUMBER.

NON-MEDICATIONS ONLY

PATIENT IDENTIFICATION: Data from ID plate

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER	TIME OF ORDER	INITIALS: Time Noted and Transcribed	INITIALS: Time Single Order Done
8 Jul 84	1000 HOURS		
Admit ward 10B			1000 GS
Diagnosis: Septicemia			1000 GS
Place on SL list			1000 GS
CBC- done			1000 GS
Blood Cultures- done			1000 GS
UA			
CXR			

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER	TIME OF ORDER		
VS Q4°	HOURS	1000	
Diet: NPO		GS	
Activity: Bedrest			
John Doe Maj MC [PRESCRIBER STAMP]			

Figure 11. Example of the method of accounting for orders--single actions and delayed orders for DA Form 4256-2 (TEST)

15. Method of discontinuing orders. To discontinue a medication or treatment, a stop order must be written and signed by the prescriber. Automatic stop orders (e.g., antibiotics, controlled substances) will be governed by local written policy. When an order is stopped, it is noted in the column Time Noted and Transcribed (as described in para 14 above). The corresponding order on DA Form 4677-1 (TEST) or DA Form 4678-1 (TEST), is discontinued using the notation DC/time/date/iitials above a diagonal line drawn across the grid adjacent to the stopped order. In the case of a single line order, a horizontal line is drawn across the grid adjacent to the stopped order. The initials in the grid blocks are bracketed to indicate no further use of the blocks. Use of any highlighter is not authorized. (See fig 12.)

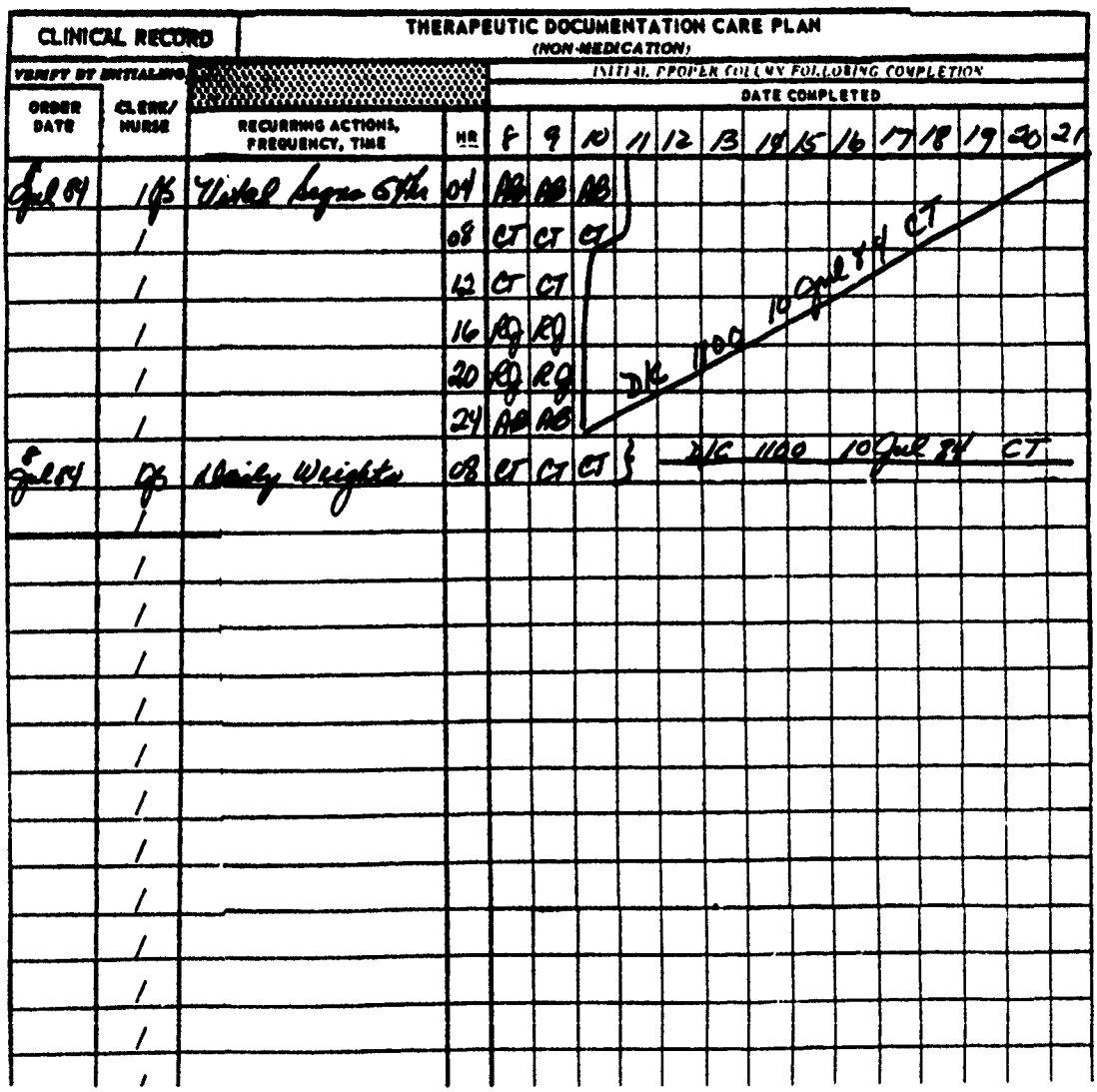


Figure 12. Example of the method of discontinuing orders for DA Form 4677-1 (TEST)

16. Verbal orders. Verbal orders will be confined to emergency STAT orders. The RN accepting the order must make an entry on the form noting the order, followed by: VO/doctor's name/nurse's name, rank, and title. The order must be countersigned by a physician immediately following the emergency. (See fig 13.)

17. Telephone orders. Telephone orders will be held to the minimum, and accepted only by an RN (with third-party verification whenever possible); they must be countersigned by the prescriber within 24 hours. The RN accepting the order must make an entry on the form noting the order, followed by: TO/doctor's name/nurse's name, rank, and title. (See fig 13.)

CLINICAL RECORD - DOCTOR'S ORDERS FOR MEDICATIONS

For use of this form, see DA Ltr 40-85- , the proponent agency is the Office of The Surgeon General.

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM-ORIENTED MEDICAL RECORD SYSTEM INDICATE PROBLEM NUMBER.

MEDICATIONS ONLY

PATIENT IDENTIFICATION	DATE OF ORDER / TIME OF ORDER	INITIALS: Time Noted and Transcribed	INITIALS: Time Single Order Done
VERBAL ORDER Must be countersigned immediately after the emergency	8 Jul 84 1200 HOURS Lasix 10mg IV STAT VO Dr John Doe / Nurse Smith, Jane RN		
NURSING UNIT / ROOM NO. / BED NO.			
PATIENT IDENTIFICATION	DATE OF ORDER / TIME OF ORDER		
TELEPHONE ORDER Countersigned within 24 hours	8 Jul 84 1800 HOURS Tylenol 650mg po q 4 hr prn temp > 101 TO Dr John Doe / Nurse Smith, Jane RN		
NURSING UNIT / ROOM NO. / BED NO.			
PATIENT IDENTIFICATION	DATE OF ORDER / TIME OF ORDER ____ HOURS		
NURSING UNIT / ROOM NO. / BED NO.			
PATIENT IDENTIFICATION	DATE OF ORDER / TIME OF ORDER ____ HOURS		

Figure 13. Example of verbal orders and telephone orders for DA Form 4256-1 (TEST)

SECTION V. - CLINICAL RECORD--THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION), DA FORM 4677-1 (TEST)

18. Purpose. This form, printed on colored paper, is for non-medication doctor's and nurse's orders. Medical orders will be transcribed from DA Form 4256-2 (TEST). Nursing orders, initiated by the RN, and written on this form, will be so indicated by placing NO/nurse's initials in the initialing column. If appropriate, corresponding nursing interventions written as nursing actions or orders on this form will reflect the number of the identified nursing problems or nursing diagnosis. (See fig 14.) Currently approved overprints of nursing or physician orders may be reprinted on the test form during the course of the CNR Study.

CLINICAL RECORD — THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	8	9	10	11	12	13	14	15	16	17	18	19	20	21
8 Jul 81	NO/JS	Log Cont. Actions	07-15														
	/	"	15-23														
	/		23-07														
	/																
	/																
	/																
	/																
	/																
	/																

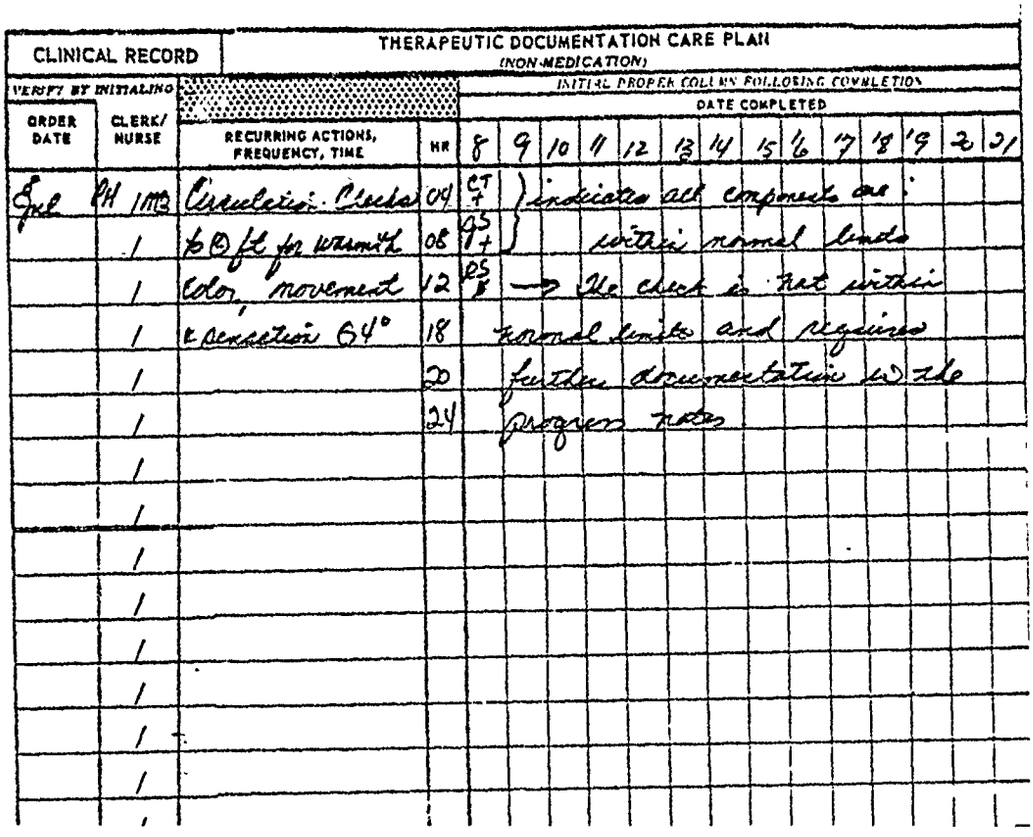
Figure 14. Example of a nursing order for DA Form 4677-1 (TEST)

This form is also used to document patient care and patient response to nursing intervention. Codes (see fig 15), printed on the form may be used throughout this entire form and are as follows:

a. Initials only--When placed in the designated block, indicates that the order has been completed.

b. Initials and +--Indicates that the nursing intervention and/or observation are satisfactory and/or within normal limits. This documentation requires no further explanation in the progress notes if the nursing or medical order completely describes actions and/or observations.

c. Initials and Ø--Indicates the results of nursing intervention and/or observation are unsatisfactory. This code also may indicate that the nursing intervention or observation was not observed or was omitted. Use of this code always requires further documentation in the progress notes.



CLINICAL RECORD — THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING COMPLETION — DATE COMPLETED

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	8	9	10	11	12	13	14	15	16	17	18	19	20	21
8/2	RH IMB	Circulation: Checks	04	CT +	} indicates all components are												
	/	to ft for warmth	08	QS +			within normal limits										
	/	color, movement	12	QS	→ No check is not within												
	/	sensation 64°	18		normal limits and requires												
	/		20		further documentation in the												
	/		24		progress notes												
	/																
	/																
	/																
	/																
	/																
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	/																
	/																
	/																
	/																

Figure 15. Example of the use of the results codes on DA Form 4677-1 (TEST)

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

20. Allergies. Specify the presence or absence of allergies. When known, indicate specific allergen.

21. Primary diagnosis. Enter admission diagnosis, or a corrected one, as a definitive diagnosis is made or another condition develops. Add other diagnoses if they significantly affect care to be given.

22. Recurring actions (see fig 16). a. Order Date. Enter the date that the current order was written.

b. Initialing. The individual who transcribes an order must initial the specified block. The RN must co-initial all orders not transcribed by an RN. The nurse's initials indicate that this person checked the accuracy of the transcription against the order on the doctor's order form and is, therefore, accountable for its accuracy and its appropriateness from a nursing standpoint.

c Recurring Actions, Frequency, Time. This section is used for recurring actions when compliance with the order is repetitive and scheduled. The complete order, as originally written, must be transcribed to this section.

d. Hour. Specific times are listed vertically. Each space is for a separate time of action. In those instances where actions are required every 1 to 2 hours, two times may be entered in one block. Placement of initials must correspond to placement of the designated time. Orders which are pervasive throughout the shift and are not time-related or sensitive (e.g., seizure precautions, intake and output, activity levels, etc.) are indicated by designating the inclusive times for each shift; e.g., 07-15, 15-23, 23-07.

e. Date. The top row of spaces is used to indicate the day the action is accomplished.

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

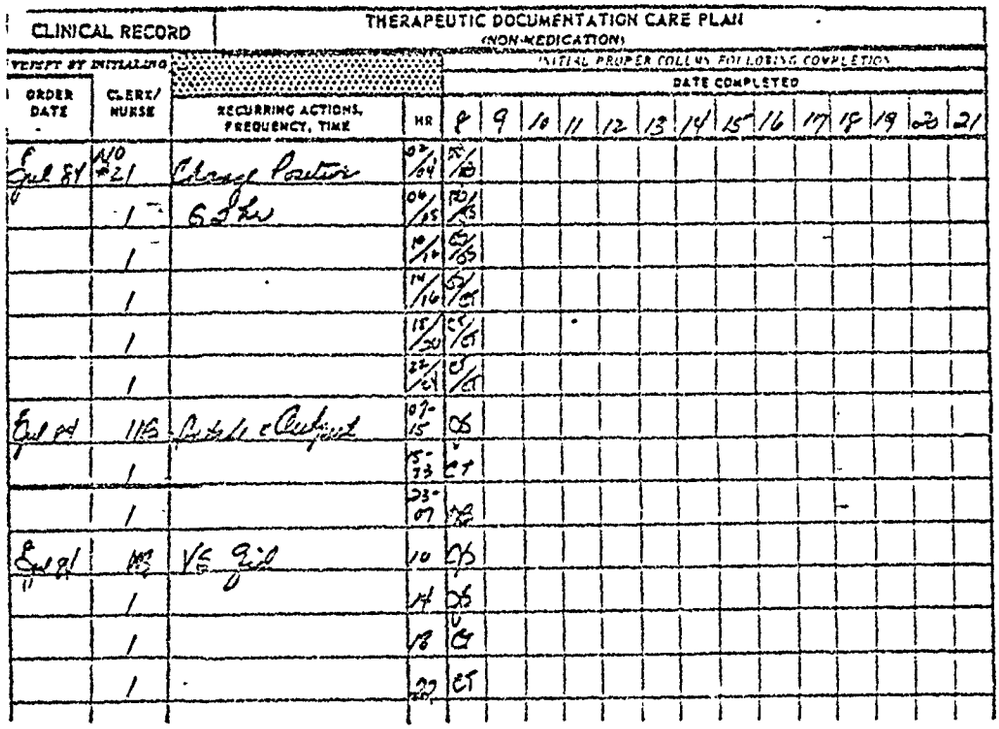


Figure 16. Example of recurring actions on DA Form 4677-1 (TEST)

g. Use of DA 4677-1 (TEST) as a flowsheet. If a frequently recurring order requires the recording of an assessment (e.g., color of an extremity) or objective measurement (e.g., vital sign), the DA 4677-1 (TEST) may be used as a flowsheet. All assessment or measurement components must be specified in the order. Unused portions of the form are to be lined out.

h. Discontinued order. When an order is discontinued, a diagonal line is drawn across the remaining blocks (if a single line order, a horizontal line is used). DC/date/time/initials is written above the line. The initials in the grid blocks are bracketed to indicate no further use of the blocks. Use of any highlighter is not authorized. (See fig 17.)

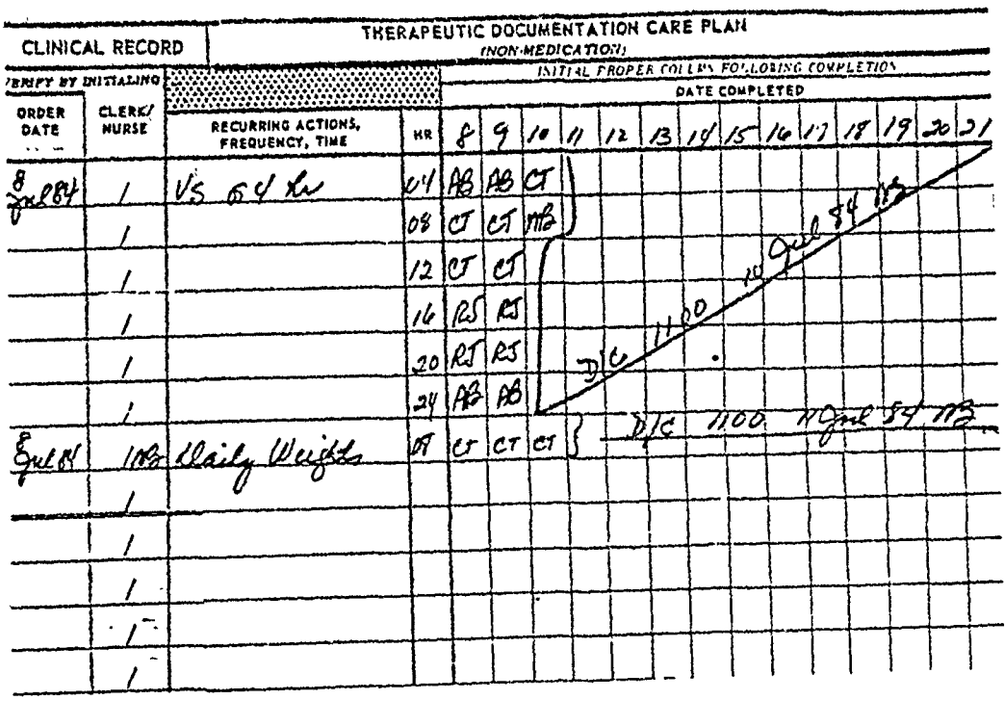


Figure 17. Example of the method for discontinuing orders for the DA Form 4677-1 (TEST)

23. Single actions, delayed orders (see fig 18). a. Delayed order. If a single action order is not completed within the responsible RN's tour of duty, the order becomes a delayed order and is transcribed (rewritten) to the Single Actions, Delayed Orders column.

b. Order Date. Enter the date the current order is written.

c. Initialing. The individual who transcribes an order will initial the specified block. The RN must co-initial all orders not transcribed by an RN. The RN's initials indicate that this person checked the accuracy of the transcription against the order on the DA Form 4256-2 (TEST) and is, therefore, accountable for its accuracy and its appropriateness from a nursing standpoint.

d. Single Actions, Delayed Orders. The complete order, as originally written, must be transcribed to this column.

e. To Be Done. Enter the date and time, if known, the action is to be taken. Indicate "on call" if so ordered.

f. Completed. Enter the date/time/initial the order was completed. If the order is not completed, specify the reason and initial in the given block. Further elaboration may be made in the progress notes.

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION) For use of this form see DA Letter XXX-85, the proponent agency is the Office of the Surgeon General		
Order Date	Clerk Nurse	SINGLE ACTIONS, DELAYED ORDERS	TO BE DONE	COMPLETED
8 Jul	KT	CBC	9 Jul 0800	
8 Jul	KT	Abdominal Ultrasound	9 Jul 0/c	D/C 1113
8 Jul	KT	CXR PA & Lat	8 Jul ASAP	8 Jul 0900
	/			
	/			
	/			
	/			
	/			
	/			
	/			
	/			

Figure 18. Example of single actions, delayed orders for DA Form 4677-1 (TEST)

24. PRN actions. Use when the time of an order is not predictable. (See fig 19).

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

b. Initialing. The individual who transcribes an order must initial the specified block. The RN must co-initial all orders not transcribed by an RN. The RN's initials indicate that this person checked the accuracy of the transcription against the order on the DA Form 4256-2 (TEST) and is, therefore, accountable for its accuracy and its appropriateness from a nursing standpoint.

c. PRN Action, Frequency. Indicate the action to be taken and its frequency.

d. Time/Date/Reason/Initials. Each block indicates a separate action. The person completing the action enters the date, time, initials, and if applicable, the reason indicating the necessity of the action, at the time of completion. Results codes (see para 18) may be used as appropriate.

THERAPEUTIC DOCUMENTATION CARE PLAN (NON MEDICATION)									
Order Expir Date	Clerk Nurse	PRN ACTION, FREQUENCY	INITIAL UPON ENTRY FOLLOWING COMPLETION TIME/DATE/REASON/INITIALS/EFFECTIVENESS CODE						
8 Jul 84	/ KT	Blood Cultures for T>102° oral	1000 8 Jul 84 First						
/	/								

Figure 19. Example of PRN actions for DA Form 4677-1 (TEST)

25. Recopied orders. a. When space in the Date Completed column is filled, a double line is drawn across the entire page just below the last entry. Directly below this double line, or on a like blank form, Recopied Orders is written, the dates for coming days are filled in, and each order still in effect, to include the date of the original order, is recopied. The individual copying the orders; if other than an RN, will follow the initialing procedures as previously described. The responsible RN will verify these orders by initialing the proper column. The person transcribing the orders authenticates by signature, rank or status at the end of the transcription. (See fig 20.)

CLINICAL RECORD — THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)

VERIFY BY INITIALING				INITIAL PROPER COLUMN FOLLOWING COMPLETION														
ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED														
				8	9	10	11	12	13	14	15	16	17	18	19	20	21	
8 Jul 84	CC/CT	VS q 8 hr	08	CT	CT	CT	KR	KR	KR	WW	WW	WW	ST	ST	ST	ST	ST	
	/		16	MS	AB	AB	AB	AB	KW	EW	WW	KW	CD	CD	CD	DS	DS	
	/		24	DS	AB	JS	QS	QS	BY	BY	BT	DS	DS	DS	DS	DS	DS	
8 Jul 84	AR/AT	Diet Regular	07	CT	AB	CT	KR	KR	KR	WW	KW	WW	ST	ST	ST	ST	ST	
	/		12	MS	AB	AB	KR	KR	KR	WW	WW	WW	ST	ST	ST	ST	ST	
	/		18	MS	AB	AB	AB	AB	WW	EW	WW	KW	CD	CD	CD	DS	DS	
8 Jul 84	RC/CT	Activity - Up Ad lib	07-15	CT	CT	CT	KR	KR	KR	WW	WW	WW	ST	ST	ST	ST	ST	
	/		15-23	MS	AB	AB	AB	AB	KR	WW	WW	WW	CD	CD	CD	DS	DS	
	/		23-07	DS	DS	DS	DS	DS	BY	BY	BY	DS	DS	DS	DS	DS	DS	
8 Jul 84	AR/AT	Daily Wt	08	CT	CT	CT	KR	KR	KR	WW	WW	WW	ST	ST	ST	ST	ST	
	/	RECOPIED ORDERS																
	/			22	23	24	25	26	27	28	29	30	31	1 Aug 84	2	3	4	
8 Jul	RS	VS q 8 hr	08															
	/		16															
	/		24															
8 Jul	DS	Diet Regular	07															
	/		12															
	/		18															
8 Jul	DS	Activity Up Ad lib	07-15															
	/		15-23															
	/		23-07															
8 Jul	DS	Daily Wt	08															
	/	Verna A Smith Cpt ANC																
	/																	

Figure 20. Example of recopied orders for DA Form 4677-1 (TEST)

b. In the event that orders need to be recopied before the Date Completed column is filled, the order is indicated as recopied by a diagonal or single line drawn across the remaining blocks. Recopied/date/initials are written above the line. Existing initials are bracketed to indicate no further use of the remaining blocks. (See fig 21)

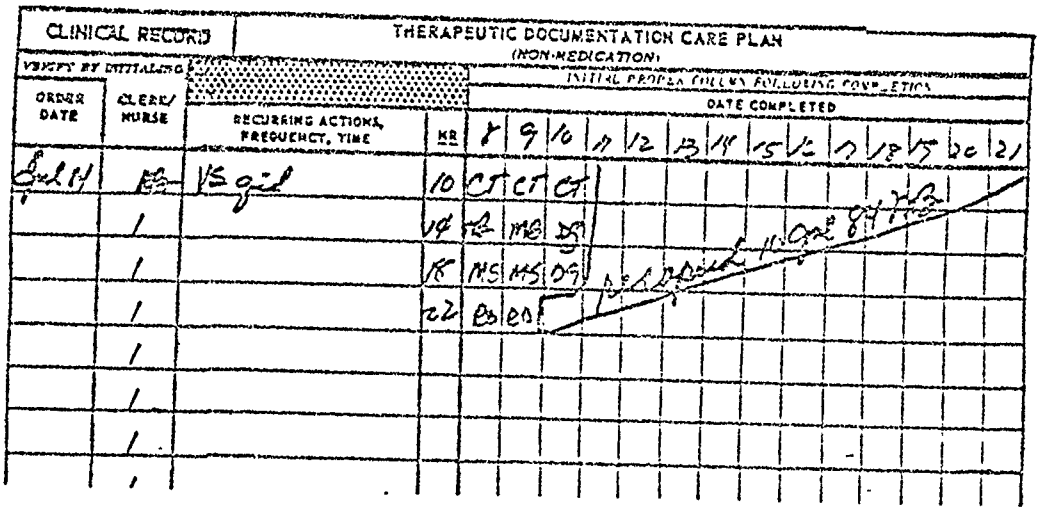


Figure 21. Example of recopied orders with unfilled Date Completed area for DA Form 4677-1 (TEST)

SECTION VI. CLINICAL RE[illegible]D--THERAPEUTIC DOCUMENTATION CARE PLAN, (MEDICATIONS), DA FORM 4678-1 (TEST)

26. Purpose. This form, printed on white paper, is for medication doctor's orders and accompanying nursing orders which pertain to the administration of the ordered medication. Medication orders will be transcribed from DA Form 4256-1 (TEST). Nursing orders, initiated by the RN, and written on this form, will be so indicated by placing NO/nurse's initials in the initialing column. (See fig 22.) Currently approved overprints of nursing or physician orders may be reprinted on the test form during the course of the CNR Study.

CLINICAL RECORD — THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 1	2	3	4	5	6	7	8	9	10	11	12	13	14
6 OCT	NO/[illegible]	Pt prefers	08														
	/	Nebcomid	20														
	/	reject with 05															
	/																
	/																

Figure 22. Example of nursing order for DA Form 4678-1 (TEST)

This form is also used to document patient response to the medication intervention. Codes (see fig 23), printed on the form, may be used throughout the form as appropriate and are as follows:

a. Initials only--When placed in the designated block, indicates that the medication (order) has been admimistered (completed).

b. Initials and E--Indicates that the administered medication was effective. It achieved the desired results as specified in the original order; i.e., if given for pain, the pain was relieved; if given for agitation, the patient is less agitated. This documentation requires no further explanation in the progress notes.

c. Initials and I--Indicates that the administered medication was ineffective or did not achieve the desired results, as specified in the original order; i.e., if given for pain the pain was not releived; if given for agitation, the patient remains agitated. The use of this code requires a notation regarding the activity and its results in the progress notes.

d. Initials and Ø--Indicates that the medication was not administered as ordered. This documentation requires a notation in the progress notes regarding the reason for omission and subsequent followup if appropriate.

The effectiveness codes can be used for all controlled substances as well as PRN medications other than controlled substances, e.g., milk of magnesia, Mylanta, etc.

CLINICAL RECORD		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)															
VERIFY BY INITIALING				INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION													
ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 1	2	3	4	5	6	7	8	9	10	11	12	13	14
6/18	SH	Valium 5mg po	06	MP E													
		BCHS	12	RD E													
			16	RW I	(	notation must be further explained in progress notes											
			24	SH S	)												

Figure 23. Example of the use of codes for DA Form 4678-1 (TEST)

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

28. Allergies. Specify the presence or absence of allergies. When known, indicate specific allergen.

29. Primary diagnosis. Enter admission diagnosis, or a corrected one as a definitive diagnosis is made or another condition develops. Add other diagnoses if they significantly affect care to be given.

30. Recurring medications (see fig 24). a. Order Date. Enter date of the current order.

b. Initialing. The individual who transcribes an order must initial the specified block. An RN must co-initial all orders at the earliest possible time regardless of who transcribes (rewrites) the order. An RN cannot co-initial an order which he or she has transcribed. The RN's initials indicate that this person checked the accuracy of the transcription against the order on DA Form 4256-1 (TEST) and is, therefore, accountable for its accuracy and its appropriateness from a nursing standpoint.

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

d. Hour. Specific times are listed vertically. Each space is for a separate time of administration. In those instances where medications are ordered every 1 to 2 hours, two times may be entered in one block. Placement of initials must correspond to placement of the designated time. Orders which are pervasive throughout the shift and are not time-related or sensitive (e.g., IV rates, oxygen administration, etc.) are indicated by designating the inclusive times for each shift; e.g., 07-15, 15-23, and 23-07.

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

f. Initialing. The responsible person will initial the block opposite each specific hour line for administration and under the appropriate date column to verify compliance with the order. The effectiveness of the medication may be recorded in the same block by using the codes (see para 26).

CLINICAL RECORD		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)															
VERIFY BY INITIALING				INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION													
ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED													
				1	2	3	4	5	6	7	8	9	10	11	12	13	14
6/6 RJ	PH/MB	FeSO4 325mg	10	MB													
	/	PO BID	18	HC													
6/6 RJ	PH/MB	Macrox 30cc	06/22	AS/AS													
	/	PO 6-2° fluz	10/14	MB/MB													
	/	0600 - 2300	14/14	MB/MB													
	/		14/18	HC/HC													
	/		22/13	HC/AR													
6/6 RJ	PH/MB	O2 by mask	07-15	AR													
	/	3 L/min	15-23	HC													
	/		23-07	AS													
	/																

Figure 24. Example of recurring medications for DA Form 4678-1 (TEST)

g. Discontinued order. When an order is discontinued, a diagonal line is drawn across the remaining blocks (if a single line order, a horizontal line is to be used). DC/date/time/initials is written above the line. The initials in the grid box are bracketed to indicate no further use of the blocks. Use of any highlighter is not authorized. (See fig 25.)

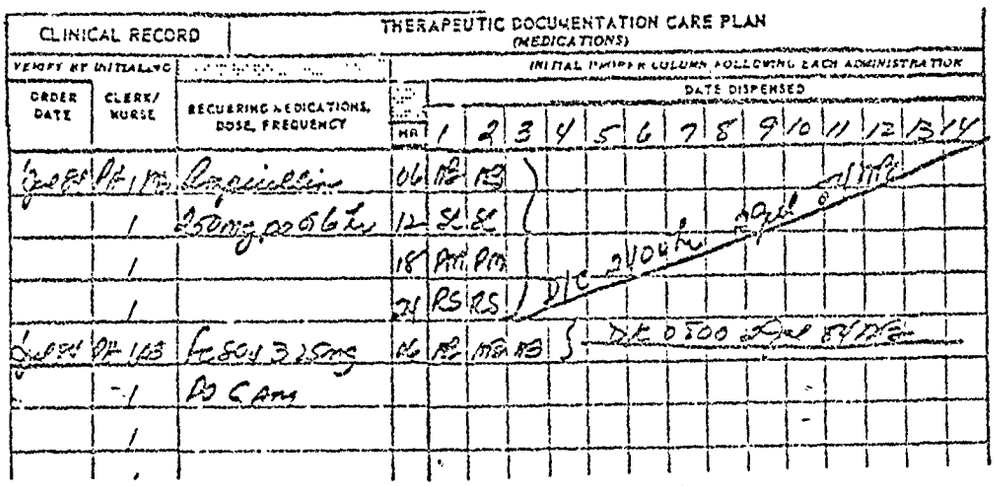


Figure 25. Example of the method for discontinuing orders on the DA Form 4678-1 (TEST)

31. Single actions, delayed orders, preoperatives (see fig 26). a. A single action medication order which is not completed within the responsible RN's tour of duty becomes a delayed order and is transcribed (rewritten) to this section.

b. Order Date. Enter date of the current order.

c. Initialing. The individual who transcribes an order will initial the specified block. An RN must co-initial all orders at the earliest possible time regardless of who transcribes the order. The RN's initials indicate that this person checked the accuracy of the transcription against DA Form 4256-1 (TEST) and is, therefore, accountable for its accuracy and its appropriateness from a nursing standpo nt.

d. Single Actions, Delayed Orders, Preoperatives. The complete order, as originally written, must be transcribed to this column.

e. To Be Given. Enter the date and time, if known, the drug is to be administered. Fill in "on call" if so ordered.

f. Date/Time Given/Initials. Date, time, and initials are entered after the medication is administered. If the order is not completed, specify the reason and initial in this block. Further elaboration may be made in the progress notes, as appropriate.

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS) For use of this form see DA Letter XXX-85; the proponent agency is the Office of The Surgeon General		
Order Date	Clerk/ Nurse	SINGLE ACTIONS, DELAYED ORDERS, PREOPERATIVES	TO BE GIVEN	DATE GIVEN/ TIME/INITIALS
9/28	PH SC	Seconal 100mg po @2100 hs	Qhs 2100	9/28 Refused
9/28	PH SC	Demerol 100 mg Inm q/4 h pc	2pc o/c	2pc 0800
	/			
	/			
	/			
	/			
	/			
	/			
	/			

Figure 26. Example of single actions, delayed orders, preoperatives entry for DA Form 4678-1 (TEST)

32. PRN medications. Use when the time of administration is not predictable. (See fig 27.)

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

b. Initialing. The individual who transcribes an order must initial the specified block. An RN must co-initial all orders at the earliest possible time regardless of who transcribes the order. The RN's initials indicate that this person checked the accuracy of the transcription against the order on DA Form 4256-1 (TEST) and is, therefore, accountable for its accuracy and its appropriateness from a nursing standpoint.

c. PRN Medication, Dose, Route, Frequency, Reason. Indicate the medication to be administered, dose, route, frequency, and reason; e.g., Demerol, 50 mg, IM, q4H prn, pain.

d. Time/Date/Reason/Initials/Effectiveness Code. Each block indicates a separate action. The person completing the action enters the time, date, initials, reason for administration, and the code designating the effectiveness of the medication (see para 26 for code explanation). If a choice of route or dose is given in the order; e.g., PO or IM, (50-75 mg), specify the route and dose administered.

THERAPEUTIC DOCUMENTATION CARE PLAN
(PRN MEDICATIONS)

Drug/Treat Date	Clerk/Nurse	PRN MEDICATION, DOSE, ROUTE, FREQUENCY, REASON	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE/REASON/INITIALS/EFFECTIVENESS CODE						
2 Feb 89	AP / BS	Seconal 100 mg po HS prn insom	2200 2 Feb 89 Insom MS E	0900 3 Feb 89 Slept 6½ hrs	THIS ENTRY COUNTERSIGNED NOTATION IN THE PROGRESS NOTES (e.g. as below)				
3 Feb 89	AP / BS	Seconal 100 mg po HS prn insom	2200 3 Feb 89 Insom MS E	0700 4 Feb 89 Slept 7½ hrs MS					
/ /	/ /								
/ /	/ /								

DATE	MEDICAL RECORD / PROGRESS NOTES
2 Feb 89	2200 NCO Notes: Pvt Jones wants to get to sleep. States that he was in training at Ft Stewart 100 mg po given 2200 per order. Cardiac exam WNL. Pt reminded about curfew & told to notify nurse if he cannot sleep. Call MD Green for additional sleep orders. Pt states he had no further questions. Knows how important it is for Pt to have surgery soon. Hope Pt will use it. Talked about surgery possibility. Seconal 100 mg po repeated per MD Green. R. Brown RN BSC
3 Feb 89	0700 NCO Notes: Pt was resting quietly. Did not appear tired. Bonjoie Brown RN BSC

Figure 27. Example of PRN medication and use of codes for DA Form 4678-1 (TEST) and SF 509

33. Recopied orders. a. When space in the Date Dispensed column is filled, a double line is drawn across the entire page just below the last entry. Directly below this double line, or on a like blank form, Recopied Orders is written, the dates for coming days are filled in, and each order still in effect, to include the date of the original order, is recopied. The individual copying the orders will follow the initialing procedures as previously described. The responsible RN will verify these orders by initialing the proper column. The person transcribing the orders authenticates by signature, rank, or status at the end of the transcription. (See fig 28.)

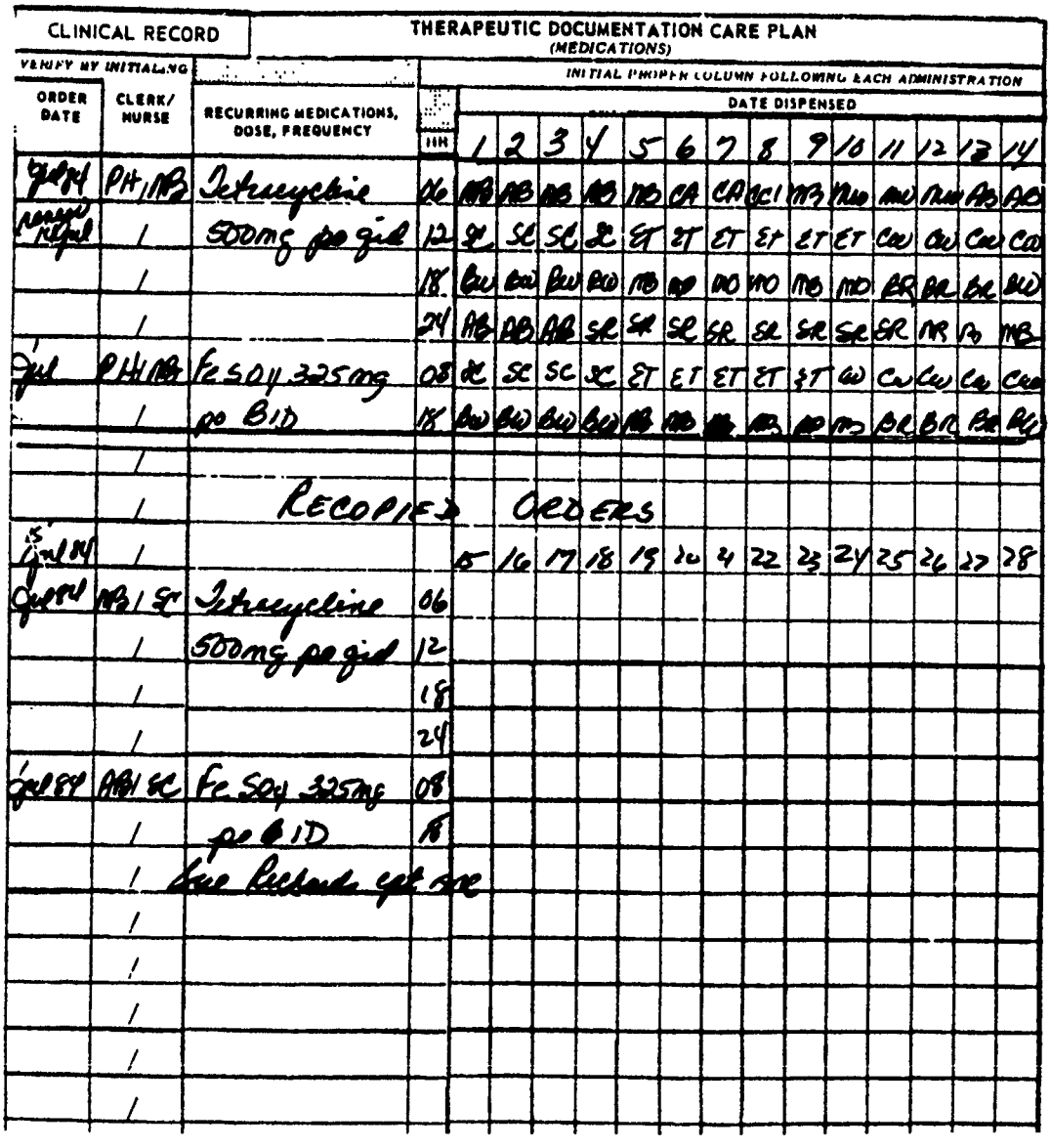


Figure 28. Example of recopied orders for DA Form 4678-1 (TEST)

b. In the event that orders need to be recopied before the Date Dispensed column is filled, the order is indicated as recopied by a diagonal or single line drawn across the remaining blocks. Recopied/date/initials are written above the line. Existing initials are bracketed to indicate no further use of the remaining blocks. (See fig 29.)

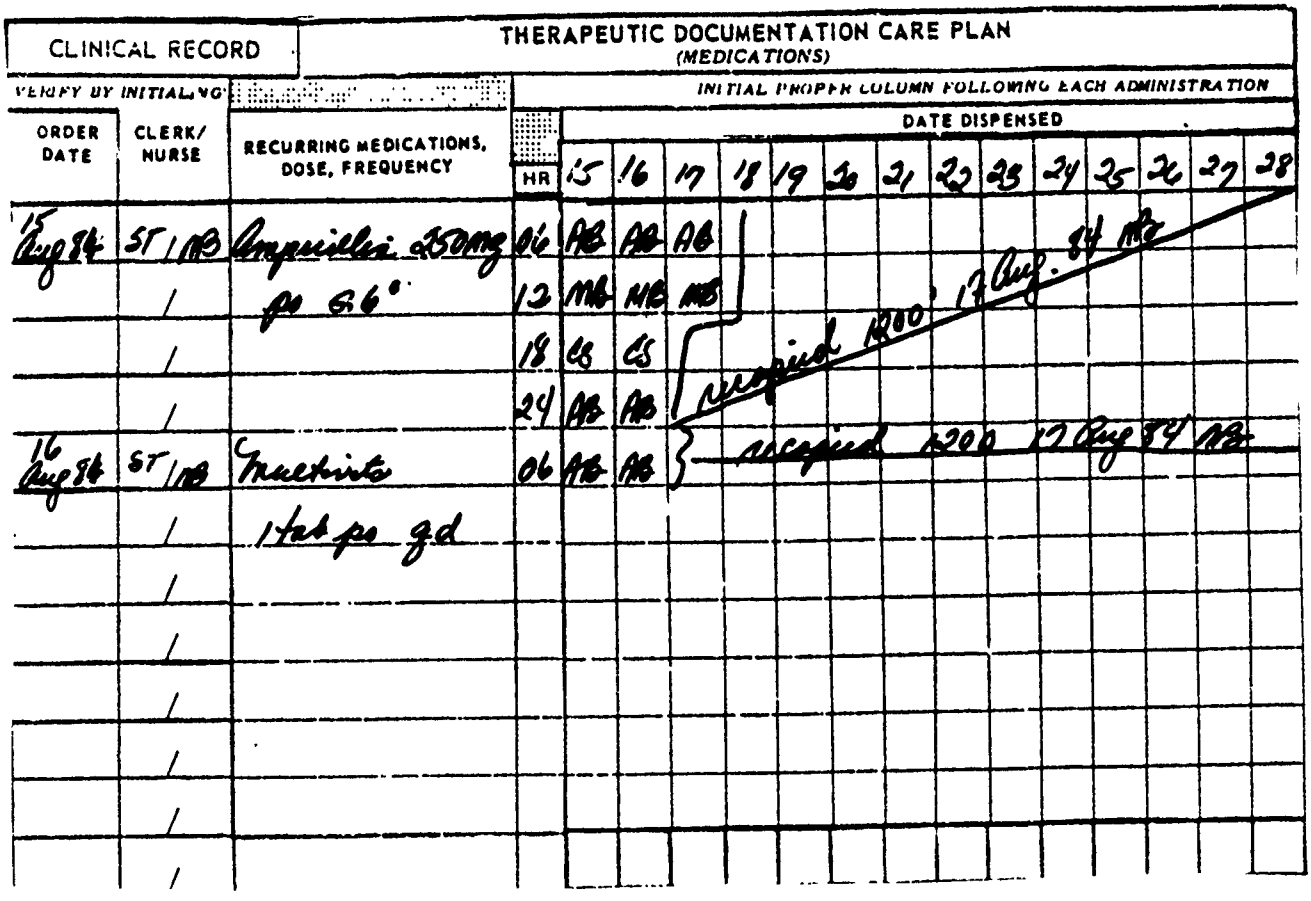


Figure 29. Example of recopied order with unfilled Date Dispensed area for DA Form 4678-1 (TEST)

SECTION VII. CLINICAL RECORD--NURSING NOTES, SF 510

34. Use. This form will not be used for the duration of the CNR Study. All narrative nursing notations will appear on the SF 509.

SECTION VIII. CLINICAL RECORD--PROGRESS NOTES, SF 509

35. Purpose. In accordance with AR 40-66, paragraph 7-11b, "...Progress notes will describe chronologically the clinical course of the patient. They should reflect change in condition and results of treatment...."

36. General. For the period of the CNR Study, an integrated approach will be taken towards the writing of progress notes. Health team members, including all nursing personnel, will record on the same form in a chronological sequence. This promotes reading of each other's notations, avoids duplication, decreases total charting required, and enhances quality and continuity of care.

a. The nursing progress notes begin with an admission note, unless one was written on DA Form 3888-2 (TEST) when the patient was admitted. They continue with notes during hospitalization and conclude with a final note on discharge or death.

b. Nursing personnel will continue to use DA Forms 4677-1 (TEST) and DA Form 4678-1 (TEST), and other approved flowsheets to indicate routine activities or therapy. Specific notations of the patient's response will be written on SF 509, depending on the prescribed circumstances further defined in these guidelines.

c. The patient's record will show progress or lack of progress, which--

(1) Documents objective evidence of treatment and procedures.

(2) Indicates that medical orders are followed and appropriate care is given by respective departments.

(3) Documents observations that describe and answer questions regarding what the patient does, how he or she does it, and how he or she looks.

(4) Documents patient interactions or subjective statements which describe what the patient says, how he or she says it, and how he or she feels.

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

38. Format of notations. Notations on the narrative progress notes may be diary style or problem oriented. No specific charting format is mandated. However, components of the nursing process; i.e., assessment, plan, implementation and evaluation, should be evident in the progress notes written by the nursing personnel. The following "mechanics" for writing the note are to be followed:

a. All notations will be made in black or blue-black ink.

b. Each notation will be preceeded with the date and time of the entry and the nursing care plan problem(s) to be reflected in the progress note. (See fig 30.) The problem may be listed by number or name. Such identification will facilitate location of a previous nursing entry and tracking of nursing interventions for quality assurance. If there are no specific nursing care plan problems to be reflected in the progress notes, a note is to be preceeded with the words "Nursing Entry" or "Nursing Note".

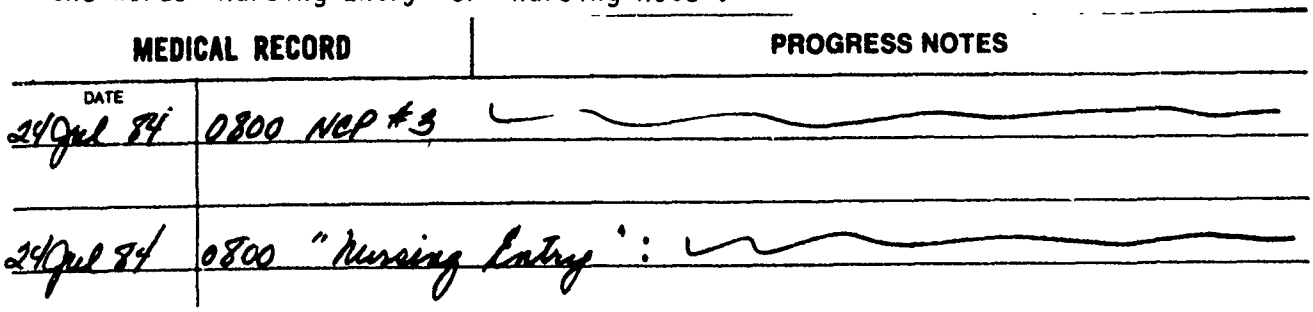


Figure 30. Example of nursing notation for SF 509

c. Multiple problems may be referenced in one note provided they are identified in the opening notation. (See fig 31.)

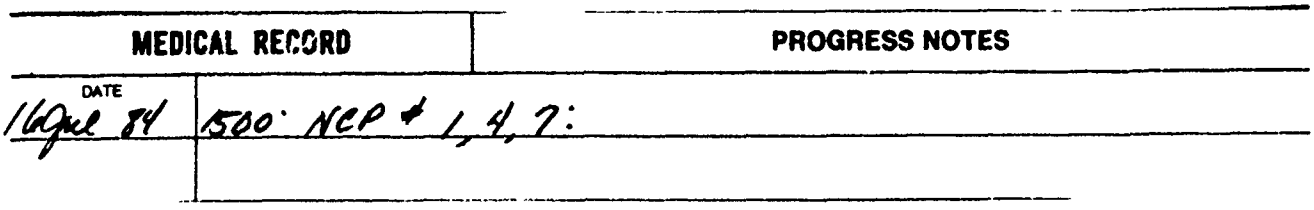


Figure 31. Example of multiple problems referenced in progress note for SF 509

d. All notes will close with the signature, rank, and title of the person making the notation. A line is to be drawn to complete unused space as necessary. (See fig 32.)

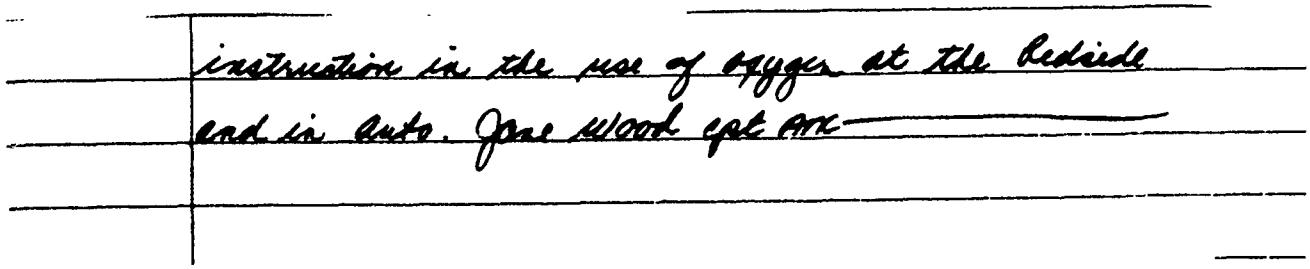


Figure 32. Example of close of progress note for SF 509

e. Entries out of chronological order may be made by first noting the date and time of the current notation, followed by an indication that this is a recording of an event out-of-sequence. No attempt is to be made to "squeeze" in this data to fit the sequence of notations. (See fig 33.)

16Jul84	0800 "Late Entry" NCO #3 @ 0600: the patient suddenly became diaphoretic, clutched his chest and yelled "HELP!" ... CONTINUE WITH NOTE AS APPROPRIATE

Figure 33. Example of an out-of-sequence progress note for SF 509

f. A mistake is not erased. A line is to be drawn through the error and marked "error in recording" followed by a notation of the correct information. The error is not to be obliterated. (See fig 34.)

~~8July84~~	~~0600 NCP #3: Pt. was found diaphoretic and clutching.~~ ERROR IN RECORDING J Smith MAJAN

Figure 34. Example of an error in charting for SF 509

g. Standard abbreviations as specified in AR 40-66, Appendix B will be used.

h. Block charting, such as the notation of "0700-1500," is not to be used to provide a summary comment of happenings during the preceeding timeframes. Rather, the specific time the notation is being made is stated, followed by the summary statement. (See fig 35.)

16Jul84	1400 Shift Summary 0700-1400 NCP #14 O: No significant change since AM assessment A: Stable P: Continue to monitor and implement current nursing plan. Mary J. Atkins LCPL/MC —

Figure 35. Example of a summary statement for SF 509

39. Frequency of charting. Frequency of charting will be dictated by the patient response and professional responsibility and judgement of those authorized to chart on this form (see para 40 below).

a. If used appropriately, DA Form 4677-1 (TEST) and DA Form 4678-1 (TEST), will subsume the majority of incidental and routine charting related to the efficacy of nursing interventions and other patient responses. The coding systems on these forms indicate when charting is to be done on other than "satisfactory or within normal limits" or "effective, achieved desired results" occurrences. Hence, if a less than desired result or response is noted, a problem has arisen and the subsequent notation by the nursing personnel in the progress notes will be problem oriented. However, this does not preclude the writer from making a notation on a patient even in those instances where all has gone according to plan. For example, a note may be necessary to add continuity or to provide a succinct summary of a shift's activity.

b. If no notation appears, it indicates that the previous status exists and the patient received care in relation to the medical orders and care of other health professionals; no unusual observations were made; and no unusual activities or incidents were noted. Hence, charting will be based primarily on exceptions to the expected course of the patient's treatment.

c. Notations should be made on any shift as frequently as necessary to record changing conditions, interventions, and responses during serious or critical problems.

40. Nursing personnel authorized to chart on the SF 509. All nursing personnel are authorized to chart on the SF 509.

a. Progress notes review. Documentation in any form by other than the RN does not absolve the RN (i.e., head nurse, charge nurse, team leader, etc.) of the responsibility for professional supervision and review of nursing care. The RN must assess the individual nursing provider's skill level. The head nurse, or designee, must consider the quality of the progress notes written by the paraprofessional or RN to be meeting professional standards and medical and legal requirements. Additional training may be done on an individual basis between the head nurse and staff members, by the nursing education and training service at the MTF, or as otherwise designated by the chief nurse. The head nurse will periodically review progress notes written by staff members.

b. Nursing student charting. The issue of student charting will be negotiated by the Chief, Department of Nursing at the MTF and the faculty representative of the nursing program.

41. Content. What the recorder determines to be pertinent is related to his or her nursing judgement. However, several points are emphasized:

a. Documentation of patient transportation to and from the following areas is to be made:

(1) Operating room.

(2) Recovery room.

(3) Treatment off the MTF premises.

(4) Transfer to another unit.

It is not necessary to chart routine successful transportation to various treatment areas, such as physical therapy, radiology, etc. Exceptions, however, will be charted.

b. Some single action orders will require an assessment of the intervention's efficacy. If such an order has not been transcribed to either DA 4677-1 (TEST) or DA 4678-1 (TEST), the assessment must appear in the progress notes. In most instances, this will apply to STAT procedures performed, or medications administered during a change in the patient's condition. For example, anginal pain unrelieved by the ordered medication is subsequently relieved by a STAT dose of another substance as ordered by the physician. Such a notation describing the problem and following activities must appear in the progress note. If there is any question whether a single order not transcribed needs to be noted on the progress note, NOTE IT!) (See fig 36.)

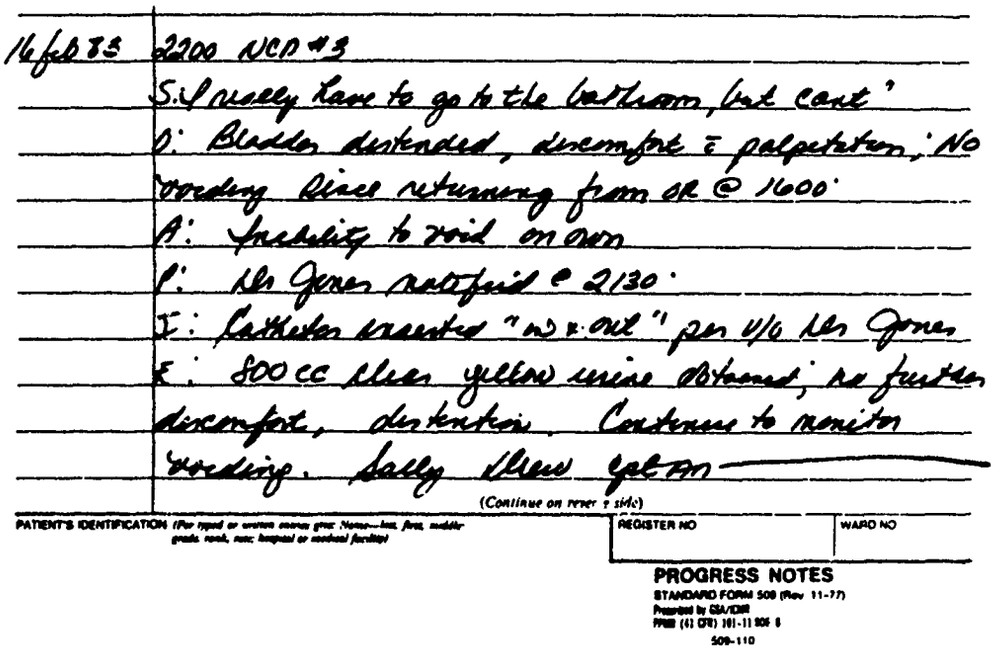

16 Feb 83 2200 NCN #3
S: I really have to go to the bathroom, but can't"
O: Bladder distended, discomfort ± palpitation; No voiding since returning from OR @ 1600.
A: Inability to void on own
P: Dr Jones notified @ 2130.
I: Catheter inserted "in & out" per O/O Dr Jones
E: 800 cc clear yellow urine obtained; no further discomfort, distention. Continue to monitor voiding. Sally Rhew Cpt USN
(Continue on reverse side)
PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle grade, rank; name hospital or medical facility)
REGISTER NO
WARD NO
PROGRESS NOTES
STANDARD FORM 509 (Rev 11-77)
Prescribed by GSA/ICMR
FPMR (41 CFR) 101-11.806 8
509-110

Figure 36. Example of charting a single action for SF 509

c. Negative statements should be avoided unless they serve a useful purpose. Without a new statement, the previously documented status exists, since charting is based on exceptions to the expected course of the patient's treatment. Entries such as "denies pain" implies that the patient has been asked if he or she has any pain; "no complaints" indicates that the patient did not volunteer any information. Examples of significant negatives which may be included are--

(1) "Dressing dry" immediately after surgery and once each shift for the first 24 hours. If at any time, it is draining, then a notation will be made until it is again dry.

(2) For a non-elective patient who is admitted with a specific pain, a statement regarding the pain or absence of it should be noted at least once each shift for the first 24 hours. If the patient does not have pain, it does not have to be recorded shift after shift with entries such as "denies pain" or "no complaints".

d. Generalized, judgemental statements without supporting facts on which such judgements were made are to be avoided. For example, "Patient seems to accept the loss of her baby without seeming too upset." (What was said to make the nurse think this?) Quote the patient directly, more frequently, on all shifts. For example, "6 July 84, 0800, NCP #3, Sally has said, 'the doctor told me the baby's heart wasn't formed right. She wouldn't have a normal life.' Patient tearful, husband at bedside, Chaplain here too."; then later, "6 July 84, 1600, NCP #3, Mrs. Stewart walking in the hallway with husband, said to the nurse 'I had a good cry this morning, but it still will take time, won't it?' Attempts to smile, has put on makeup and wearing own clothes rather than hospital PJs. Seems to be working through the grieving process. Continue to support and allow opportunities to express feelings."

e. Be specific as the situation is seen. Avoid using the terms "appears" and "seems" unless additional data is given. "Appears" may only be appropriate in relation to sleep since it may be difficult to determine. Record concisely.

f. Correlate what is seen with what is known. For example, if the patient's respirations were shallow when checked for the first time, chart whether they are less shallow or the same the next time. If the pulse was weak, the next time chart whether the pulse has become weaker or stronger. Since such judgements are subjective, only the person making the first judgement can determine whether or not a change has occurred. Another example: If a particular medication is suspected as the cause when the patient develops blurred vision or any symptoms that might be caused by the medications he or she is taking, chart the drug received immediately after the symptoms. Keep in mind that the medications are charted on a separate form from the progress note.

g. While, as much as possible, the narrative notes should emphasize progress or lack of progress, there are some situations of accountability which may be recorded in the progress notes. Examples of such accountability information are--

(1) "Yellow metal wedding band removed from safe at wife's request and given to her to take home."

(2) "Dr. _____ here, told patient tissue report was positive for cancer, but he felt they got it all and would treat with radiation as an added precaution."

(3) "Dr. _____ was told 'patient respiration had increased to 40; BP down from 120/66 at 0830 to 84/40 at 0845. Pulse up from 88 to 126; condition poor, etc'".

(4) "Dr. _____called to inquire about patient's condition."

(5) "c/o dizziness after taking shower. Instructed not to be up when dizzy; patient unsteady on feet. Instructed to put light on when he needs to get up. Told to put the call light on when he asked what he was to do if he needs to get up. He said, 'Light on' when asked what he would do if he needs to get up." (Record instructions given to the patient).

h. Finally, it can be helpful to look at notes from other disciplines to gain insight into the assessment process at various stages of the patient's recovery.

SECTION IX. MEDICAL RECORD--NURSING DISCHARGE SUMMARY, DA FORM 3888-5 (TEST)

42. Purpose. DA Form 3888-5 (TEST) is used to facilitate summarizing of the patient's progress or lack of progress, provide the patient with a copy of written instructions upon discharge, and summarize data to ensure audit criteria have been met.

a. Areas of instructions and patient's response have been documented elsewhere in the patient record (progress notes, approved teaching flowsheets, etc.). The discharge summary pulls together information scattered throughout the chart.

b. DA Form 3888-5 (TEST) is the "discharge nursing note" and suffices for a lengthy notation at discharge on the SF 509. All that is required on the SF 509 when the discharge summary is completed is "patient discharged, see DA Form 3888-5 (TEST)," or words to that effect.

43. Preparation. DA Form 3888-5 (TEST) is a three-part carbonless form completed at the time of discharge. The original copy becomes part of the patient's inpatient treatment record; the second copy is reviewed with the patient and retained by him or her or the family; the third copy is placed in the outpatient treatment record.

a. Entries may be made by nursing personnel. However, regardless of what information is recorded, and by whom, the RN is ultimately responsible for ensuring the accuracy and completeness of the entries, and for reviewing the instructions with the patient or significant other person prior to discharge.

b. All patient identification information is to be entered in the space provided on the form.

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

a. Complete the form as specified by each section of the summary.

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

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

MEDICAL RECORD — NURSING DISCHARGE SUMMARY

For use of this form, see DA Ltr 40 85- , the proponent agency is the Office of The Surgeon General

Date/Time:	Discharged to: ☑ Home Other (Specify)	Accompanied by:
15 Jun 84 0700	Mode: ☑ Ambulatory Other (Specify)	wife

I. ACTIVITY. ☐ No Restrictions Limitations (Specify) _____

Yes MD Patient and/or Significant Other (S.O.) communicates knowledge and understanding of activity limitations.

II. DIET: ☐ No Dietary Restrictions If special, identify 1500 Calorie low sodium diet

Yes Patient/S.O. communicates understanding of dietary restrictions.

III. MEDICATIONS: ☐ No Medication Required

Name of Medication	Dosage	Frequency of Medication	Special Instructions
Cabpres	0.1mg	twice a day	take 1 tablet on rising & 1 at bedtime

Yes MD Patient and/or Significant Other (S.O.) communicates knowledge and understanding of name, dosage, frequency and special instructions.

IV. TREATMENTS/CARE:

Instructions Given:	Patient/S.O. Observed Demonstration (Date)	Patient/S.O. Returned Demonstration (Date)
1. Taking own BP-use of equip; recording results	13 Jun 84	13-14 Jun 84

Equipment/Supplies (Specify) NA

V. FOLLOWUP: You should be seen in MEDICAL clinic in 1 WK (time period).

Important Telephone Numbers: Emergency Room 12345 Central Appointment 678910 Ward 1112131 4 Clinic 15161718

Appointment ☐ No appointment needed

☐ An appointment is to be made by the patient at _____

☒ An appointment has been made at MEDICAL clinic on 22 JUN 84 at 1000 hours.

☒ Referral Initiated Seen by dietician for diet instru. Will make F/u with CAS in 1 wk

Yes Patient/S.O. communicates understanding of followup instructions.

VI. PATIENT'S CONDITION (Health Status relative to Nursing Care Plan): Physical condition essentially normal except for obesity and controlled hypertension. Pt & wife (Vivian) interest & concern in control & maintenance of high BP. They are hoping diet control will assist weight problem.

Signature (Registered Nurse): Rachael Brown RCTANC

Patient Identification: DATA from ID Plate.

Additional Information: Adm BP 170/98 D/C BP 130/80

DA Form 3888-5 (TEST)

Figure 37. Example of a nursing discharge summary for DA Form 3888-5 (TEST)

CLINICAL NURSING

RECORDS STUDY

A PROGRAMMED INSTRUCTION

CLINICAL NURSING RECORDS STUDY

A PROGRAMMED INSTRUCTION

Purpose

The purpose of this program is to enable you to correctly use the newly developed Clinical Nursing Records Study Forms.

Objectives

Upon completion of this program you will be able to--

1. Account for doctor's orders in the correct manner on the Clinical Record--Doctor's Orders for Medications, DA Form 4256-1 (TEST).

2. Account for doctor's orders in the correct manner on the Clinical Record--Doctor's Orders for Non-medications, DA Form 4256-2 (TEST).

3. Correctly use the Clinical Record--Therapeutic Documentation Care Plan (Medications), DA Form 4678-1 (TEST).

4. Correctly use the Clinical Record--Therapeutic Documentation Care Plan (Non-medication) DA Form 4677-1 (TEST).

5. Account for Single Action and Delayed Orders.

6. Appropriately use codes to indicate results and effectiveness of nursing actions.

7. Correctly use in an integrated manner, the test forms and the Clinical Record--Progress Notes, SF 509.

Instructions

1. Each new frame presents some new information or reviews material previously presented.

2. Write your response(s) in the spaces provided in the program.

3. Look at the correct response(s) only after you have made your own response.

4. The programmed text is designed to be used in conjunction with the Clinical Nursing Records Study--Form Guidelines. You should have copies of all test forms and guidelines for reference as you read through the text.

5. The following short titles for each test form described in the programmed text are listed below.

Note. Short titles are indicated in parenthesis following the full form name and number.

a. Medical Record--Nursing History and Assessment, DA Form 3888-2 (TEST) (Nursing History and Assessment form)

b. Medical Record--Nursing History and Assessment (Continued), DA Form 3888-3 (TEST) (Nursing History and Assessment Continuation form)

c. Medical Record--Nursing Care Plan, DA Form 3888-4 (TEST) (Nursing Care Plan form)

d. Clinical Record--Doctor's Orders for Medications, DA Form 4256-1 (TEST) (Doctor's Orders for Medication form)

e. Clinical Record--Doctor's Orders for Non-medications, DA Form 4256-2 (TEST) (Doctor's Orders for Nonmedication form)

f. Clinical Record--Therapeutic Documentation Care Plan (Non-medication), DA Form 4677-1 (TEST) (Nonmedication Therapeutic Care Plan form)

g. Clinical Record--Therapeutic Documentation Care Plan (Medications), DA Form 4678-1 (TEST) (Medication Therapeutic Care Plan form)

h. Medical Record--Nursing Discharge Summary, DA Form 3888-5 (TEST) (Nursing Discharge Summary form)

CONTENTS

PART I
GENERAL

Read Down The Page

---

1. AR 40-407 governs the use of the doctor's orders and nursing records. However, for the test of the proposed new forms, the special guidelines will be used.

The use of the doctor's orders and nursing records is governed by AR___-_____; however, for the test of the proposed new forms _____ _____ will be used.

AR 40-407,
special guidelines

---

2. Registered nurses on the unit are responsible for the completeness, accuracy, and appropriateness of entries made by the paraprofessional personnel they supervise.

No answer required.
Go on to the next frame.

---

3. Initiation of a permanent clinical record is an essential part of the inpatient admission procedure.

Initiation of a permanent clinical record is an essential part of the _____ _____ _____.

inpatient admission procedure

4. Entries may be printed or written in longhand, but must be legible.

Clinical record entries may be _____ or _____ in longhand.

printed; written

5. All entries will be made with a pen using reproducible black or blue-black ink.

Entries on clinical records must be made with a _____ using _____ black or _____ ink.

pen; reproducible; blue-black

6. Erasures of any information in the clinical record are prohibited.

You are _____ from _____ any information in the clinical record.

prohibited; erasing

7. To correct an error, a line will be drawn through an incorrect entry. The initials of the person making the entry will be placed above the lined out entry. Correct information will be recorded following the lined out entry.

Errors are corrected by _____ through the incorrect entry and _____. Correct information will be recorded _____ the entry.

---

lining; initialing; following

---

8. A basic requirement in the preparation of all clinical records is to enter the patient's identifying information. The addressograph plate contains all necessary information. This information includes: The patient's last name, first name, middle initial, rank, hospital number, social security number (sponsor's social security number will be used for dependents), the date, name of the facility, and nursing unit.

No answer required.
Go on to the next page.

PART II

THE NURSING PROCESS

---

9. The nursing process is a systematic, problem solving thought process which is essential to accomplishing specific, predictable, individualized care. The process consists of four phases: a. Assessment and appraisal, b. planning, c. implementation, and d. evaluation.

The _____ _____ is a systematic, problem solving thought process which is essential to accomplishing specific, predictable, individualized care. The process consists of four phases: a. _____, b. _____, c. _____, and d. _____.

---

nursing process;
assessment and appraisal;
planning;
implementation;
evaluation

---

10. The assessment and appraisal are the nursing history: the gathering of data from the patient, other informed persons, and patient records. Based on the history, the RN completes a nursing assessment and initiates a plan of care. The assessment phase is completed within 24 hours of the patient's admission.

The assessment and appraisal are the _____ _____ : the gathering of data from the patient, other informed persons, and patient records. Based on the history, the RN completes a nursing assessment and initiates a plan of care. The assessment phase is completed within _____ _____ of the patient's admission.

---

nursing history, 24 hours

---

11. Planning is the development of the nursing care plan which is devised from the initial and on-going assessment of the individual patient's needs. The care plan consists of a problem list, expected outcomes or goals, and discharge considerations to be accomplished by nursing intervention. Planned nursing interventions are written as nursing orders. The nursing orders are a vital means of communicating nursing interventions to all care providers. The nursing orders are essential for accountability and responsibility in the documentation of care.

Planning is the development of the nursing care plan which is devised from the _____and ____-_____ assessment of the individual patient's needs. The care plan consists of a problem list, expected outcomes or goals, and discharge considerations to be accomplished by nursing intervention. Planned nursing interventions are written as _____ _____. The nursing orders are a vital means of communicating nursing interventions to _____ _____ _____ _____.

initial; on-going;
nursing orders;
all care providers

12. Implementation of the nursing process includes nursing actions determined by the nursing care plan. The delegation of nursing care to other care providers is the responsibility of the head nurse or designated charge nurse. The implementation phase concludes when the nurse's actions are completed and recorded.

Implementation of the nursing process includes nursing actions determined by the nursing care plan. The delegation of nursing care to other care providers is the responsibility of the head nurse or designated charge nurse. The implementation phase concludes when the nurse's actions are _____and _____.

completed; recorded

13. Evaluation is considered in terms of how the patient responded to the planned action. Evaluation of the effects of actions during and after the implementation phase determines the patient's response and the extent to which immediate, intermediate, and long-range goals were achieved. This evaluation phase is also documented.

Evaluation is considered in terms of how the patient _____ to the planned action. Evaluation of the effects of actions during and after the implementation phase determines the _____ _____ and the extent to which immediate, intermediate and long-range goals were achieved. This evaluation phase is also documented.

---

responded, patient's response

---

14. The Army Department of Nursing records complement each other so that when the clinical record is reviewed, the documentation will reflect the nursing process, i.e., assessment of the patient, planning, implementing and evaluating the nursing care to meet the patient's individual needs. All forms must be completed. Forms which document the nursing process consist of--

a. A nursing history (interview) and assessment on the Nursing History and Assessment form, DA Form 3888-2 (TEST).

b. A nursing care plan documenting identified patient problems (or nursing diagnoses, as appropriate), goals, and discharge considerations on the Nursing Care Plan form, DA Form 3888-4 (TEST).

c. Plans documented as nursing orders on the Therapeutic Documentation Care Plan forms, Non-medication, DA Form 4677-1 (TEST), and Medication, DA Form 4678-1 (TEST).

d. Discharge preparations, documented as a nursing discharge summary on the Nursing Discharge Summary form, DA Form 3888-5 (TEST).

e. Evaluation of the patient's progress and effectiveness of nursing interventions as documented on the Clinical Record--Progress Notes (SF 509), the Therapeutic Documentation Care Plan, Non-medication, DA Form 4677-1 (TEST), or the Therapeutic Documentation Care Plan, Medication, DA Form 4678-1 (TEST).

The Army Department of Nursing records complement each other so that when the clinical record is reviewed, the documentation will reflect the nursing process, i.e., assessment of the patient, planning, implementing, and evaluating the nursing care to meet the patient's individual needs. All forms must be completed. Forms which document the nursing process include--

a. A nursing history (interview) and assessment on the _____ _____ _____ form, DA Form 3888-2 (TEST).

Nursing History and Assessment

---

b. The nursing care plan documenting identified patient problems (or nursing diagnoses, as appropriate), discharge considerations, and goals recorded on the _____ _____ _____ form, DA Form 3888-4 (TEST).

Nursing Care Plan

---

c. Plans documented as nursing orders recorded on the _____ _____ _____ _____ _____ form, DA Form 4677-1 (TEST).

Therapeutic Documentation
Care Plan, Non-medication

---

d. Discharge preparations documented as a nursing discharge summary recorded on the _____ _____ _____ form, DA Form 3888-5 (TEST).

Nursing Discharge Summary

---

e. Evaluation of the patient's progress and effectiveness of nursing interventions documented on the _____ _____ (SF 509), the _____ _____ _____ _____, DA Form 4677-1 (TEST), or the _____ _____ _____ _____, DA Form 4678-1 (TEST).

Clinical Record--Progress Notes;
Therapeutic Documentation Care Plan, Non-medication;
Therapeutic Documentation Care Plan, Medication;

Go on to the next page.

PART III

TEST FORMS

Note. Short titles are indicated in parenthesis following the full form name and number.

Medical Record--Nursing History and Assessment, DA Form 3888-2 (TEST)

(Nursing History and Assessment form)

15. Data entered on this form represents baseline health status information needed by the nurse to plan care. The information may be obtained from the patient, other informed persons, and the patient records.

The front portion of the form, containing a brief series of questions, provides a guideline for the interview. Date and time of admission with admitting diagnosis (as specified by the physician) are to be recorded in the provided spaces. Responses by the patient may be recorded next to the questions in the provided area. If additional space is required, the history may be continued on the History and Assessment Continuation form, DA Form 3888-3 (TEST). Spaces are provided for the recording of information to assist in contacting next of kin, or in their absence, another person designated as a point of contact (e.g., company commander, first sergeant, support person, etc.) for concerns arising as a result of the hospital episode. The person collecting the data is to sign name, rank , and title and list from whom the data was obtained in the "informant" area (e.g., "patient," "mother- Mrs. John Doe," etc.). A space is provided for the noting of the disposition of articles brought to the hospital. Initialing of the disposition by the interviewer attests to where such items were consigned. It is not interpreted to mean the interviewer was the one who actually placed the article(s) in the designated area. The nursing history (interview) is obtained by the nursing personnel.

The reverse side of the Nursing History and Assessment form provides an area for additional assessment data. The nursing assessment is completed and recorded by the registered nurse within 24 hours of admission. If completedand recorded at admission it will serve as the admission nursing note. The nursing assessment is reviewed and updated as additional data are collected and patient needs and potentials change.

It is important to take note that the RN may use multiple modalities to collect patient data from which a plan of care is developed which addresses identified needs and potentials. <u>However, regardless of what data is collected, and by whom, the registered nurse is ultimately charged with the responsibility to ensure validity and reliability of the collected data.</u>

No answer required.
Go on to the next page.

EXAMPLE: Nursing History and Assessment form, DA Form 3888-2 (TEST)

MEDICAL RECORD · NURSING HISTORY AND ASSESSMENT

For use of this form see DA Ltr 40-88 the proponent agency is the Office of the Surgeon General

Date and Time of Admission	Admission Diagnosis
27 June 83 1900	Diabetes Mellitis

	YES	NO	Patient's own words when possible
1 Tell me what you know about your illness/injury/ hospitalization			I have alot of sugar and take pills and shots I've been losing so much weight and go to the bathroom all the time.
2 Do you have any other health problems?		✓	Pt. responds "No" However daughter indicates frequent episodes of confusion, inability to move from bed to chair & bed side
3 Have you been hospitalized before? If so when and for what?		✓	Preg loop · 6 x past 8 months for same dx
4 What medications have you been taking? (to include prescription and over the-counter drugs) For how long?			Lente Insulin 20 u qd
5 Are you allergic to anything? If so what? What reaction?		✓	
6 Do you have any special needs that require assistance with daily activities? (e.g. diet eating bathing elimination ambulating sleeping aides or prosthetic devices)	✓		Help to get out of bed, walking, uses walker. Help with all ADLs Soft diet - wears upper dentures - no lower teeth or dentures. Daughter states I do all I can - the can," has admits she doesn't understand diabetes very well.
7 What other concerns do you have?			
8 How can we be most helpful?			"Let me alone."

Name of Local Contact/NOK	Relationship	Telephone Number
Elizabeth Caudle	daughter	123-4567

Interviewer's Signature Rank & Title	Informant
James Smith 1LT DOC	patient + daughter

Patient identification

From ID plate

PERSONAL ARTICLES AND VALUABLES
(indicate disposition of each item by initials)

Item	Bedside	Home	Treasurer	Other (Specify)
eye glasses	JS			
dentures	JS			
Cash - 7/c			JS given to daughter	

DA FORM 3888-2 (TEST) (Continue on reverse)

EXAMPLE: Nursing History and Assessment form (Reverse side)

MEDICAL RECORD–NURSING HISTORY AND ASSESSMENT

ADDITIONAL ASSESSMENT DATA

ADMISSION: TPR 1:2 - 100 - 36 BP 220/110 WT 232 lbs HT 66"

DATE/TIME 27 June 83 1950

(In accordance with the Army Medical Department Standards of Nursing Practice-DA Pam 40-5)

A nursing assessment includes a minimal statement on General Appearance, Age Sex, Race, Height, Weight, Physical Disabilities,as applicable, Condition of the Skin, Behavior indicative of mental-emotional status. Data on the bio-phvsical status, in the categories listed below, as appropriate for planning care, is also included in the admission assessment. "Appropriate" is the key word. Each category does not have to be addressed if it is not adding information necessary to provide nursing care.

S/p white female admitted via u/c with medical dx of diabetes, mellitus x 15 years, recently on latest insulin (as per Hx) Cc polyuria, polydypsia anorexia, wt loss in last 6 months & previous admission for same cc pain & numbness in feet & hands. Appears alert, answers questions appropriately, but daughter states pt becomes confused, disoriented and wanders frequently at night.

Physical assessment shows a debilitated woman, body odor, patient incontinent of urine & bowels, decubitus on ⓒ buttocks 2x3 cm, sacral decubitus 5x11cm, both draining purulent material. Ankles bruised and legs reddened. Patient admits periods of dizziness and has fallen at home x2. Skin turgor poor, tongue swollen, mucous membranes dry. Ecchymosis on ⓒ hip and elbow.

Signature (Registered Nurse)

Jane Smith 1LT ANC

ASSESSMENT CATEGORIES

1. Growth and Development
2. Neurological
   a) Orientation
   b) Level of Consciousness: alert, drowsy, lethargic, comatose. Responses to verbal and painful stimuli. Ability to follow commands. Reflexes
   c) Describe abnormalities
3. Eyes, Ears, Nose, and Throat
   a) Eyes: Pupils, vision
   b) Ears: Hearing, drainage
   c) Nose: Rhinorrhea, nasal surgery/trauma
   d) Throat: Sore, difficulty swallowing, appearance on inspection, lymph nodes
   e) Describe abnormalities
4. Cardiovascular
   a) Skin: Color, temp, turgor, moisture
   b) Peripheral Circulation: Pulses, edema, extremities
   c) IV's: Contents of bottle hanging, bottle number, condition of site
   d) Pain: Location, radiation, duration, type, relief
   e) Intrathoracic tubes and/or dressings
5. Pulmonary
   a) Respirations: Rate, regularity, effectiveness, depth, use of accessory muscles, nocturnal/expernal dyspnea. Chest movement associated with respirations
   b) Breath sounds: Clear to auscultation, Rales, Rhonchi, Wheezes, etc.
   c) Oxygen: Percent given: liters/min, method of administration, continuous or PRN
   d) Cough, sputum, suctioning
6. Gastrointestinal
   a) Abdominal: Auscultation (bowel sounds present), palpitation, abdominal girth measurement (if applicable)
   b) Dressings and/or drains
7. Genitourinary
   a) Urination: Continency, pattern change
   b) Female: Vaginal discharge, LMP, last PAP smear (if applicable), etc.
   c) Male: Abnormal discharge, swelling, pain
8. Integumentary
   a) Lesions, pressure points, contractures
   b) Color, moisture, edema, turgor, change in pigmentation
9. Musculoskeletal
   a) Movement: Purposeful/Non Purposeful, ROM, muscle strength, level of usual activity
   b) Foot care (as applicable): TED hose
10. Psycho-Social
    a) Adjustment to hospitalization and illness, manner, mood, behavior, relation to persons around them

REFERENCE: DA Pam 40-5 AMEDD Stds of Nursing Practice

DA FORM 3888-2 (TEST) (Reverse)

Medical Record--Nursing History and Assessment (Continued), DA Form 3888-3 (TEST)

(Nursing History and Assessment Continuation form)

16. The Nursing History and Assessment Continuation form provides space for the continuation of data collected during either the nursing history (interview) or the nursing assessment.

EXAMPLE: Nursing History and Assessment Continuation form, DA Form 3888-3 (TEST)

MEDICAL RECORD – NURSING HISTORY AND ASSESSMENT (continued)

For use of this form see DA LTR 40-85 the proponent agency is the Office of The Surgeon General

ADDITIONAL ASSESSMENT DATA

2 April 1984 0800.

This space can be used as necessary to continue recording the nursing history or assessment information if completed at the time of admission, the documentation suffices for the admission nursing note. The entry will end with the name, rank and title of the recorder. Routine DA Form 3887-3 (TEST) may be used to record extensive information

——— John Smith RNBSC ———

(Continue on reverse side

PATIENT IDENTIFICATION

Data From ID Plate.

DA Form 3888-3 (TEST)

Medical Record--Nursing Care Plan, DA Form 3888-4 (TEST)

(Nursing Care Plan form)

17. This form should reflect the "product" of initial and on-going assessments of an individual patient's needs. The care plan consists of columns indicating the date a problem is identified, an area for problem statement, the goal to be achieved, and the date accomplished. Interventions to achieve the goal may appear as nursing orders or physician's orders on either the Nonmedication Therapeutic Care Plan form or the Medication Therapeutic Care Plan form. An area is provided to note discharge considerations which should be assessed as close to the admission date as possible. A new addition to this form appears at the bottom of the page. Nursing diagnostic categories are provided as suggested guides to stimulate thought by the registered nurse during care plan development. The Nursing Diagnostic Category Guidelines, in and of themselves, are not a problem list.

Three patient situations are provided with various care plan formats to demonstrate how a care plan can be developed at the time of admission. The various forms within this documentation system are interrelated. An integrated record with planned care is the result. Thus, no one form can "stand alone."

No answer required.
Go on to the next page.

Patient Situation 1

Mrs. Price is a 28 year old, G1, P0, Ab0, admitted 14 July 1984 in active labor. There are no fetal heart tones discernable on your initial exam. She delivers a stillborn infant male; cause of death cord related. She resides off-post in a one-bedroom apartment with husband, E-4 Eric. She has missed several OB visits according to the medical records review.

The following care plan is developed:

MEDICAL RECORD - NURSING CARE PLAN
For use of this form see DA Ltr 40 85 , the proponent agency is the Office of The Surgeon General

INSTRUCTIONS Number and initial each recording

Date Identified	Problems	Expected Outcomes (Goals)	Date Accomplished
15 Jul 84	1. Potential for health management deficit related to the process of grief resolution/Bereavement	1. Normal Grief Process extend by discharge 2. Verbalize understanding of circumstances surrounding delivery	

MEDICAL RECORD NURSING CARE PLAN (CONTINUED)
For use of this form see DA Ltr 40 85 the proponent agency is the Office of The Surgeon General

INSTRUCTIONS Number and initial each recording

Date Identified	Problems	Expected Outcomes (Goals)	Date Accomplished

Discharge Considerations
14 Jul 84 Admission Gravida 1, Para 0; ABO one bedroom apartment - one car family

Discussion:

The care plan was developed utilizing an accepted nursing diagnosis (as specified by the Fifth National Conference of Nursing Diagnosis). The goal of the nursing staff is assisting Mrs. Price to enter an acceptable pattern of grieving. Documentation to achieve this goal may be found on the-- 1) Medication Therapeutic Care Plan form (DA Form 4678-1 (TEST) to indicate physician ordered sedatives and their administration; 2) Non-medication Therapeutic Care Plan form (DA Form 4677-1 (TEST) to indicate a nurse has made a referral to the community health nurse for a home visit or to social services for an inpatient visit and/or; 3) Progress Notes form to address areas of attentive listening, provided acceptance, ventilation of emotions by the patient, or evidence of Mrs. Price's ability to learn health management in the post partum period. This care plan is in addition to, or personalizes many overprints which may be in use within the OB setting.

No answer required.
Go on to the next page.

Patient Situation 2

Mr. Jackson Pratt, 47 years old, was transferred from an outlying medical facility in a comatose state. His provisional diagnosis is "Atypical Guillian Barre." The initial assessment of Mr. Pratt reveals absence of all protective reflexes. His only fluid intake is Isocal feedings 100cc/hr per dophoff. There is no IV. Urinary output is less than 30cc/hr average. His wife is present and is the only available historian of events. She relates displeasure over previous care provided and informs you that she is seeking litigation.

The following care plan is developed:

MEDICAL RECORD – NURSING CARE PLAN
For use of this form see DA Ltr 40 85 ; the proponent agency is the Office of The Surgeon General

INSTRUCTIONS Number and initial each recording

Date Identified	Problems	Expected Outcomes (Goals)	Date Accomplished
3 June 83	1. decreased urinary output /Bm	UOP > 30 cc/hr	Reviewed 7/1/83 mb
	2. Absence of protective reflexes/Bm	Eyes, lungs, other portals free of signs of infection	Reviewed 7/1/83 mb
7/1/83	#1 restatement of above		
	#2 restatement of above		
	#3 any NEW ongoing problem		

MEDICAL RECORD NURSING CARE PLAN (CONTINUED)
For use of this form see DA Ltr 40 85 ; the proponent agency is the Office of The Surgeon General

INSTRUCTIONS Number and initial each recording

Date Identified	Problems	Expected Outcomes (Goals)	Date Accomplished

Discharge Considerations
3/6/83 Admission rotation · wife is primary care provider @ home; ongoing litigation with prior health care facility

Discussion

This care plan was developed utilizing presented patient problems. Since the patient is comatose, the care plan does not reflect a problem verbally stated by the patient . Problem 1 indicates a low urinary output with a goal of UOP>30cc/hr average. Nursing actions to meet the goals are identified in conjunction with the patient's lab data and physician's plan of care. The nursing actions would be recorded on the Nonmedication Therapeutic Care Plan form. Such actions may include--

a.	Isocal 100cc/hr	07 15 23
b.	Flush Feeding System after each 4hrs of feeding with 120cc H_2O	07 15 23
c.	Cranberry Juice 120cc every shift	07 15 23
d.	Prune Juice 120cc every shift	07 15 23

The types of fluid reflect thought by the nursing staff; i.e., free water, cranberry juice to increase acidity of urine and thereby help prevent stones, and prune juice which could be an intervention on another identified problem involving GI motility.

If the patient's length of stay exceeds an accepted timeframe set by the nursing unit which, in this instance, is 1 month, a review of the problems/nursing diagnoses is made with notation of resolution or continuation. A temporary resolution should be noted; the previously stated problem now becomes a potential problem.

No answer required.
Go on to the next page.

Patient Situation 3

Major Gerald T. Williams, 36 years old, retired, is admitted with an upper respiratory infection. He is quadriplegic as result of an accident on 12 June 1981. MAJ Williams completed an intensive rehabilitation program and was discharged home 12 June 1982. He is gainfully employed with no hospitalizations since discharge.

The following care plan is developed:

MEDICAL RECORD - NURSING CARE PLAN
For use of this form see DA Ltr 40 85 , the proponent agency is the Office of The Surgeon General

INSTRUCTIONS Number and initial each recording

Date Identified	Problems	Expected Outcomes (Goals)	Date Accomplished
16 June 84	1. Increased respiratory dysfunction related to ineffective coughing mechanism/de	Prevent resp dysfunction through utilization of assisted cough techniques 1. Improved resp function 2. Mobilization of Secretions 3. Maintenance of Patent Airway 4 Prevent Infection	

MEDICAL RECORD - NURSING CARE PLAN (CONTINUED)
For use of this form see DA Ltr 40 85 the proponent agency is the Office of The Surgeon General

INSTRUCTIONS Number and initial each recording

Date Identified	Problems	Expected Outcomes (Goals)	Date Accomplished

Discharge Considerations
16 June 84: Admission data: Quadriplegic since 6/13/81; Rehab & discharged home 6/12/82 20 hospitalizations since 82; Employed

Discussion:

This care plan again utilizes the nursing diagnosis format. There is one major goal listed with four objectives. The major goal is not achieved (accomplished) until each objective is accomplished. Nursing actions are reflected in their appropriate areas. Documentation regarding attained resolution of each objective may include, but not be limited to--

a. Improved respiratory function
   (1) Active participation of client
   (2) Improved breath sounds
   (3) Adequate ABG's
   (4) Improved pulmonary function studies

b. Mobilization of secretions
   (1) Production of sputum
   (2) Improved breath sounds

c. Maintenance of a patent airway
   (1) Performance of nonlabored breathing
   (2) Maintaining normal activities

d. Need for minimal suctioning
   (1) No. of times suctioning performed
   (2) No. of times suctioning required

Clinical Record--Doctor's Orders for Medications, DA Form 4256-1 (TEST)
(Doctor's Orders for Medication form)

Clinical Record--Doctor's Orders for Non-medications Form,
DA Form 4256-2 (TEST)
(Doctor's Orders for Nonmedication form)

18. Doctor's Orders for Medication and Nonmedication forms are three-part carbonless forms, maintained in the patient's chart. The original copy of each form remains with the permanent record. The second copy (pink) is sent to the pharmacy. The pharmacy receives a copy of ALL orders. The ward copy (yellow) is used to communicate all orders to the nursing staff.

No answer required.
Go on to the next frame.

---

19. Doctor's Orders for Medication form (DA Form 4256-1 (TEST)) is utilized for medication orders ONLY, inclusive of medications in any form: Intravenous, Oral, Intramuscular, Inhalation or Topical.

The _____ _____
_____ _____
form (DA Form 4256-1(TEST))
is utilized for medication in any form.

Doctor's Orders for Medication

---

20. 50 mg. Demerol IM q4h prn is written on the _____ _____ _____ _____ form.

CLINICAL RECORD DOCTOR'S ORDERS FOR MEDICATIONS

For use of this form, see DA Ltr 40 85 , the proponent agency is the Office of The Surgeon General

THE DOCTOR SHALL RECORD DATE TIME AND SIGN EACH SET OF ORDERS IF PROBLEM-ORIENYED MEDICAL RECORD SYSTEM INDICATE PROBLEM NUMBER

MEDICATIONS ONLY

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	INITIALS: Time Noted and Transcribed	INITIALS: Time Single Order Done
Data from ID Plate	14 Jan 84	1200 HOURS		
	Demerol 50 mg q4h prn			
	John Doe MAJ MC			
	PROVIDER STAMP			

NURSING UNIT	ROOM NO	BED NO
15A	346	1

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER		
		_____ HOURS		

NURSING UNIT	ROOM NO	BED NO

Doctor's Orders for Medication

21. The Doctor's Orders for Nonmedication form (DA Form 4256-2 (TEST)) is utilized only for nonmedication orders.

The only orders to be written the Doctor's Orders for Nonmedication form are _____.

22. Vital signs q4h will be ordered on the _____ _____ _____ _____ form.

CLINICAL RECORD DOCTOR'S ORDERS FOR NON MEDICATIONS

For use of this form see DA Pam 40-85 the proponent agency is the Office of The Surgeon General

THE DOCTOR SHALL RECORD DATE TIME AND SIGN EACH SET OF ORDERS IF PROBLEM-ORIENTED MEDICAL RECORD SYSTEM INDICATE PROBLEM NUMBER

NON-MEDICATIONS ONLY

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	INITIALS: Time Noted and Transcribed	INITIALS: Time Single Order Done
Data From ID Plate	14 Jul 87	1200 HOURS		
	Vital Signs q4h			
	John Doe major			
	[PROVIDERS STAMP]			
NURSING UNIT: 15A / ROOM NO: 346 / BED NO: 1				
PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER _____ HOURS		
NURSING UNIT / ROOM NO / BED NO				

Doctor's Orders for Nonmedication

23. Patient identification data will be entered on each form as directed by AR 40-66. Addressograph plates should be used in each part marked Patient Identification. The portion indicating nursing unit, room number and bed number may be utilized as appropriate.

NON-MEDICATIONS ONLY

PATIENT IDENTIFICATION	DATE OF ORDER / TIME OF ORDER (HOURS)	INITIALS: Time Noted and Transcribed	INITIALS: Time Single Order Done
Jordan, Peter J. 2Lt 356807 20 39022 37 34 M 24			
NURSING UNIT / ROOM NO / BED NO			

No answer required.
Go on to the next frame.

24. For either form, the prescriber will record the date and time the order is written. More than one order may be written in each section of the form. ONE order only may be written on a single line.

PATIENT IDENTIFICATION	DATE OF ORDER / TIME OF ORDER (HOURS)
Jordan, Peter J. 2Lt 356807 20 39022 37 34 M 24	14 July 1984 / 1200 HOURS
NURSING UNIT / ROOM NO / BED NO	CBC UA VS 6 4 hr Chest X-Ray - PA & Lateral John Doe major mc [STAMP]

No answer required.
Go on to the next frame.

25. Groups of orders written at one time for the same patient require one entry per sheet. Overprinted standing orders on forms must be signed by the prescriber. Nonapplicable standing orders will be lined out and initialed by the physician initiating the orders. All prescriber's signatures MUST have the prescriber's identification stamp. Orders are written sequentially with unused portions of the order form blocked out if a new form is initiated.

CLINICAL RECORD DOCTOR'S ORDERS FOR NON-MEDICATIONS

For use of this form, see DA Pam 40-81; the proponent agency is the Office of The Surgeon General

THE DOCTOR SHALL RECORD DATE TIME AND SIGN EACH SET OF ORDERS IF PROBLEM-ORIENTED MEDICAL RECORD SYSTEM INDICATE PROBLEM NUMBER

NON-MEDICATIONS ONLY

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	INITIALS: Time Noted and Transcribed	INITIALS: Time Single Order Done
Data from ID Plate	14 Jul 84	0930 HOURS		
	Admit Ward 15A			
	Diagnosis - Sepsis			
	Place on SL list			
	CBC - done			
	Blood Cultures - done			
	UA			
	Chest X-ray			
NURSING UNIT: 15A / ROOM NO: 344 / BED NO: 1				
PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER		
Data from ID Plate	VS q 4 hr	HOURS		
	Diet NPO			
	Activity - Bedrest			
	I & O			
	Gwen Clare MAJ MC [STAMP]			
NURSING UNIT: 15A / ROOM NO: 344 / BED NO: 1				

No answer required.
Go on to the next frame.

---

26. Nursing personnel will account for written orders in the right hand column entitled Time Noted and Transcribed. Two or more orders may be enclosed in a bracket with the time noted and the transcriber's initials or signature.

A column on the right entitled _____ _____ and _____ is used to account for orders. The transcriber may _____ two or more orders and note _____ and _____ or _____.

Time Noted; Transcribed
bracket; time;
initials; signature

---

27. A one-time order completed within the responsible registered nurse's tour of duty is a Single Action Order.

A _____ _____ _____ is a one time order completed within the responsible registered nurse's tour of duty.

Single Action Order

---

28. A Single Action Order requires no further nursing action once completed. The individual carrying out the order signs off the order as having been completed in the extreme right hand column entitled Time Single Order Done.

A Single Action Order requires no further _____ _____ once signed off as completed.

---

nursing action

---

29. The individual carrying out the order signs off a completed Single Action Order with time and either initials or signature. Once signed off as completed, the order requires no transcription to the Nonmedication Therapeutic Care Plan form or the Medication Therapeutic Care Plan form.

The time and initials of the _____ _____ _____ _____ _____ in the Time Single Order Done column indicates the order is completed and requires _____ _____ to the Nonmedication Therapeutic Care Plan form or the Medication Therapeutic Care Plan form.

---

individual carrying out the order; no transcription

---

30. Some single action orders (e.g., medications or procedures) will require an assessment of the efficacy of the intervention. If such an order has not been transcribed to either the Medication or Nonmedication Therapeutic Care Plan form, the assessment must appear on the Progress Notes form. Results Codes appearing on either the Medication or the Nonmedication Therapeutic Care Plan form are not authorized for use on the Doctor's Orders for Medication or Nonmedication forms.

Some single action orders (e.g., medications or procedures) will require an assessment of the efficacy of the intervention. If such an order has not been transcribed to either the Medication or the Nonmedication Therapeutic Care Plan form, the assessment must appear on the _____ _____ form. Results Codes appearing on either the Medication or Nonmedication Therapeutic Care Plan form are ____ _____ for use on either of the Doctor's Orders for Medication or Nonmedication forms.

Progress Notes; not authorized

---

31. A Delayed Order is a Single Action Order NOT completed within the responsible registered nurse's tour of duty. It MUST be transcribed to the section Single Actions, Delayed Orders on the appropriate Medication or Nonmedication Therapeutic Care Plan form.

A Single Action Order not completed within the responsible registered nurse's tour of duty is a _____ _____.

Delayed Orders must be _____ to the appropriate Medication or Nonmedication Theraputic Care Plan form.

Delayed Order; transcribed

---

32. Completed Single Action Orders and all STAT Orders must be accounted for individually. They may not be bracketed.

No answer required.
Go on to the next page.

---

33. Example of usage.

Situation: A patient is admitted to the unit at 0930 on 14 July of the current year with the following orders:

CLINICAL RECORD DOCTOR'S ORDERS FOR NON-MEDICATIONS

For use of this form, see DA Ltr 40-85; the proponent agency is the Office of The Surgeon General

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM-ORIENTED MEDICAL RECORD SYSTEM INDICATE PROBLEM NUMBER

NON-MEDICATIONS ONLY

PATIENT IDENTIFICATION	DATE OF ORDER / TIME OF ORDER	INITIALS: Time Noted and Transcribed	INITIALS: Time Singe Order Done
Use From ID Plate	14 July 0930 HOURS		
	Admit Ward 15A		
	Diagnosis - Dyspnea		
	Place on SD list		
	CBC - done		
	Blood Cultures - done		
NURSING UNIT / ROOM NO / BED NO	UA		
	Chest X-ray		
PATIENT IDENTIFICATION	DATE OF ORDER / TIME OF ORDER		
	V3 64' HOURS		
Use From ID Plate	Diet - NPO		
	Activity - Bedrest		
	I&O		
	John Doe MAJ MC [STAMP]		
NURSING UNIT / ROOM NO / BED NO			
PATIENT IDENTIFICATION	DATE OF ORDER / TIME OF ORDER HOURS		
NURSING UNIT / ROOM NO / BED NO			
PATIENT IDENTIFICATION	DATE OF ORDER / TIME OF ORDER HOURS		
NURSING UNIT / ROOM NO / BED NO			

DA FORM 4256-2 (TEST)

Edition of 1 Jul 77 is obsolete

Requirement: Using the above example, note the orders; i.e., take the action necessary to account for the orders.

Solution:

CLINICAL RECORD DOCTOR'S ORDERS FOR NON MEDICATIONS

For use of this form see DA Ltr 40-R5 , the proponent agency is the Office of The Surgeon General

THE DOCTOR SHALL RECORD DATE TIME AND SIGN EACH SET OF ORDERS IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM INDICATE PROBLEM NUMBER

NON-MEDICATIONS ONLY

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	INITIALS: Time Noted and Transcribed	INITIALS: Time Sins Order Do
Data from ID Plate	14 July 74	0930 HOURS		
	Admit Ward 15A			0945 GS
	Diagnosis - Sepsis			0945 GS
	Place on S & Diet			0545 GS
	CBC - done			0945 GS
	Blood Cultures - done			0945 GS
NURSING UNIT / ROOM NO / BED NO	UA			
	Chest X-ray			
PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER		
Data from ID Plate	VS 6 V°	HOURS	0945 GS	
	Diet NPO			
	Activity - Bedrest			
	IVO			
	John Doe MAJ MC			
NURSING UNIT / ROOM NO / BED NO	[STAMP]			
PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER		
		HOURS		
NURSING UNIT / ROOM NO / BED NO				
PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER		
		HOURS		
NURSING UNIT / ROOM NO / BED NO				

DA FORM 4256-2 (TEST) Edition of 1 JUL 72 is OBSOLETE

Go on to the next page.

34. A Stop Order must be written and signed by the prescriber. The order is then noted in the Time Noted and Transcribed column.

To discontinue a medication or treatment, a _____ _____ must be written and signed by the prescriber. When an order is stopped, it is noted in the _____ _____ and _____ column.

Stop Order; Time Noted; Transcribed

---

35. The Stop Order is transcribed to the corresponding order on either the Medication or Nonmedication Theraputic Care Plan form. DC/date/time/initials are noted above a diagonal line drawn across the grid adjacent to the stopped order. A horizontal line is drawn across the grid in the case of a single order. Initials are bracketed to preclude further use of the blocks.

No answer required.
Go on to the next frame.

---

36. Only emergency STAT orders can be accepted as Verbal Orders noted by the registered nurse with V.O. physician's name/accepting nurse, title.

Verbal Orders will be confined to

_____, _____
Orders.

Emergency, STAT

---

37. Telephone Orders will be accepted only by the registered nurse. They must be countersigned by the prescriber within 24 hours. The registered nurse will note telephone orders by T.O. physician's name/accepting nurse, title.

No answer required.
Go on to the next page.

Clinical Record--Therapeutic Documentation Care Plan (Non-Medication), DA Form 4677-1 (TEST)

(Nonmedication Therapeutic Care Plan form)

38. The Nonmedication Care Plan form is printed on colored paper for nonmedication doctor's orders and nurse's orders. The doctor's orders are transcribed from the Doctor's Orders for Nonmedication form (DA Form 4256-2 (TEST)). N.O./ nurse's initials in the initialing column will identify nursing orders.

Preparation: Enter all patient identification data as indicated.

Allergies: Specify the presence or absence of allergies. Where known, indicate the specific allergen.

Primary diagnosis: Enter admission diagnosis or a corrected one, as a definitive diagnosis is made or another condition develops. Add other diagnoses if they significantly affect the care to be given.

Nonmedication doctor's orders and nurse's orders will be transcribed to the _____ _____ _____ _____ form.

Nonmedication Therapeutic Care Plan

---

39. Patient care and patient response to nursing intervention will be documented on this form by the use of initials, + and ∅ codes.

This form will _____ patient care and patient _____ to nursing intervention.

---

document, response

---

40. Codes to document patient care and patient response to nursing interventions are located on the Nonmedication Therapeutic Care Plan form for ready reference.

No answer required.
Go on to the next frame.

---

41. Initials alone indicate an order has been completed. Initials with a + indicate the results of the nursing intervention and/or observation was satisfactory or WNL. Initials and ∅ indicate the result of intervention and/or observation is unsatisfactory.

A completed order is indicated by _____ only. A satisfactory result from nursing intervention is coded with initials and _____. Initials and _____ indicate unsatisfactory results.

initials; +; Ø

42. Use of the initials and Ø code indicating unsatisfactory results from a nursing intervention and/or observation ALWAYS requires further documentation on the Progress Notes form.

Unsatisfactory results from nursing intervention and/or observation is indicated with _____ and Ø and must _____ be documented on the _____ _____ form.

initials; always; Progress Notes

43. Vascular checks that note a decrease in circulation would be indicated with initials and Ø. Further documentation is made in the progress notes.

Requirement: On the following Nonmedication Therapeutic Care Plan form, indicate vascular checks of the R hand that show a decrease in circulation.

CLINICAL RECORD — THERAPEUTIC DOCUMENTATION CARE PLAN (NON MEDICATION)

VERIFY BY INITIALING ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 14	15	16	17	18	19	20	21	22	23	24	25	26	27
7/24	NO/JS	Vascular checks (R)	04														
	/	hand for color,	08														
	/	warmth, sensation	12														
	/	and movement	16														
	/	Q4hr	20														
	/		24														

Solution:

CLINICAL RECORD		THERAPEUTIC DOCUMENTATION CARE PLAN (NON MEDICATION)																
VERIFY BY INITIALING				INITIAL PROPER COLUMN FOLLOWING COMPLETION														
ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED														
				14	15	16	17	18	19	20	21	22	23	24	25	26	27	
14 Jul 84	NO/P	Vascular checks @	04															
	/	hand for color	08	TK														
	/	warmth, sensation	12	TK														
	/	and movement	16															
	/	64 hr	20															
	/		24															
	/																	
	/																	
	/																	
	/																	

Go on to the next frame.

Frames 44-49 concern the Recurring Action section

44. The Recurring Action section is used when compliance with the order is repetitive and scheduled. The complete order must be transcribed to this section.

When compliance with the order is repetitive and scheduled, it is transcribed to the _____ _____ _____.

Recurring Action section

45. Order Date: Enter the date the Current Order was written.

No answer required.
Go on to the next frame.

---

46. Initialing: The individual who transcribes the order must initial the specified block. A registered nurse must co-initial all orders not transcribed by a registered nurse.

All orders not transcribed by a registered nurse must be co-initialed by a _____ _____.

---

registered nurse

---

47. Hour: Specified time(s) are listed vertically. Each space is for a separate time of action. For actions required every 1 to 2 hours, two times may be entered in one block. Placement of initials must correspond to placement of the designated time. Orders that are not time related and are pervasive throughout the shift are indicated by designating the inclusive times for each shift.

No answer required.
Go on to the next frame.

---

48. The top row of spaces indicates the day the action is accomplished.

No answer required.
Go on to the next frame.

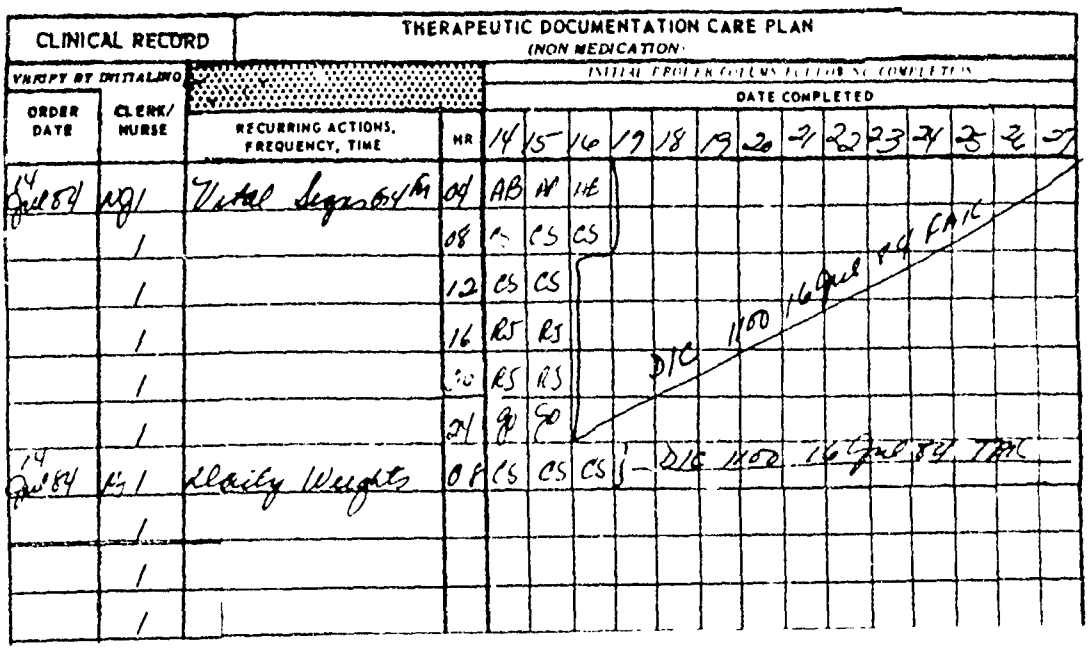
---

49. When an order is discontinued, a diagonal line is drawn across the remaining blocks (if a single line order, a horizontal line is used). DC/date/time/initials is written above the line. The initials in the grid blocks are bracketed to indicate no further use of the blocks. USE OF ANY HIGHLIGHTER IS NOT AUTHORIZED.

Requirement: Using the following example, discontinue the orders:

CLINICAL RECORD		THERAPEUTIC DOCUMENTATION CARE PLAN (NON MEDICATION)																	
VERIFY BY INITIALING				INITIAL PROPER COLUMN FOLLOWING COMPLETION															
ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED															
				14	15	16	17	18	19	20	21	22	23	24	25	26	27		
14 Jul 84	NS/	Vital Signs 6Hr	04	AB	AB	AB													
	/		08	CS	CS	CS													
	/		12	CS	CS														
	/		16	RG	RG														
	/		20	RG	RG														
	/		24	GP	GP														
14 Jul 84	NS/	Daily Weights	08	CS	CS	CS													
	/																		

Solution:



Go on to the next frame.

Frames 50-54 concern the Single Action, Delayed Orders section

50. Delayed Orders are Single Action Orders not completed within the responsible Registered Nurse's tour of duty. They will be transcribed to the Single Action, Delayed Orders section.

Delayed orders are transcribed to the _____ _____, _____ _____ section.

Single Action, Delayed Orders

51. The date the order is written and the initials of the individual who transcribes the order must appear. All orders not transcribed by a registered nurse MUST be co-initialed by a registered nurse.

No answer required.
Go on to the next frame.

---

52. The complete order must be transcribed. Enter the date and time the action is to be taken in the To Be Done column.

The date and time the action to be taken is documented in the

_____ _____
_____ column.

To Be Done

---

53. In the Completed column enter the date,time, and initial when the action was completed. If an action is not completed, indicate the reason why and place your initials in the given block. Elaborate on why on the Progress Notes form.

No answer required.
Go on to the next frame.

---

54. Example of usage.

Situation: It is now 1500, time for you to give your report, and go home. The following orders were written during your shift:

CLINICAL RECORD DOCTOR'S ORDERS FOR NON MEDICATIONS

For use of this form see DA Ltr 40-81 , the proponent agency is the Office of The Surgeon General

THE DOCTOR SHALL RECORD DATE TIME AND SIGN EACH SET OF ORDERS IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM INDICATE PROBLEM NUMBER

NON-MEDICATIONS ONLY

PATIENT IDENTIFICATION	DATE OF ORDER / TIME OF ORDER	INITIALS: Time Noted and Transcribed	INITIALS: Time Sig Order Dr
Data from ID Plate	14 July 84 — 1000 HOURS		
	Admit Ward 15		1015 JS
	Diagnosis: Abd Pain		1015 JS
	Vital Signs Q4°	1015 JS	
	CBC		1015 JS
	UA		
NURSING UNIT / ROOM NO / BED NO	NPO	1015 JS	
	Bedrest	1015 JS	
PATIENT IDENTIFICATION	DATE OF ORDER / TIME OF ORDER		
Data from ID Plate	Chest X-ray in AM — HOURS	1605 JS	
	John Doe MAS MC [STAMP]		

Requirement: Using the above orders, transcribe the Single Action Orders that have become Delayed Orders.

Verify by Initialing: Order Date	Verify by Initialing: Clerk Nurse	THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION) For use of this form see DA Letter XXX-85, the proponent agency is the Office of the Surgeon General: SINGLE ACTIONS, DELAYED ORDERS	TO BE DONE	COMPLETED
	/			
	/			
	/			
	/			
	/			
	/			

Solution:

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION) For use of this form see DA Letter XXX-85, the proponent agency is the Office of the Surgeon General		
Order Date	Clerk Nurse	SINGLE ACTIONS, DELAYED ORDERS	TO BE DONE	COMPLETED
14 Jul 87	ITA	UA	ASAP	
14 Jul 87	I	Chest X-ray	0800 15 Jul 87	
	I			
	I			
	I			
	I			
	I			
	I			

No answer required.
Go on to the next frame.

Frames 55-56 concern the PRN Action section

55. When the time of an order is not predictable, the order is transcribed to the PRN Action Frequency column, indicating the action to be taken and the frequency. The individual transcribing the order must initial in the specified block. The registered nurse must co-initial all orders not transcribed by a registered nurse.

No answer required.
Go on to the next frame.

---

56. When a PRN action is completed, it is recorded in the Time/Date/Reason/Initials/Results Code block. Each block indicates a separate action. Use of initials and + or 0 codes may be appropriate.

The person completing a PRN action enters the _____/_____/_____/_____/_____
in a block indicating an action has been taken.

Time/Date/Reason/Initials/Results Code

---

57. Orders are recopied when the Date Completed column is filled.

No answer required.
Go on to the next frame.

---

58. Orders are RECOPIED by drawing a double line across the entire page immediately below the last entry. Recopied Orders is written below the double line or on a like blank form. Dates of forthcoming days are filled in and orders still in effect recopied. THE DATE OF THE ORIGINAL ORDER is also recopied. The initialing procedures previously described will be used. The person transcribing the orders authenticates by signature, rank or status at the end of the transcription.

No answer required.
Go on to the next frame.

Situation: Recopy the orders in the following example:

CLINICAL RECORD		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)																
VERIFY BY INITIALING				INITIAL PROPER COLUMN FOLLOWING COMPLETION														
ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED														
				4	5	6	7	8	9	10	11	12	13	14	15	16	17	
4 Jul 84	TK / gs	Vital signs Q8 hrs	08	CT	CT	CT	CT	CT	TK	TK	TK	ST	ST	ST	ST	ST	ST	
	/		16	MB	MB	MB	MB	MB	FK	FK	FK	FK	FK	gc	gc	gc	gc	
	/		24	MW	MW	MW	MW	gT	gT	gT	gT	LT	LT	LT	LT	LT	LT	
6 Jul 84	TK / gs	Diet Regular	07	CT	CT	CT	CT	CT	TK	TK	TK	ST	ST	ST	ST	ST	ST	
	/		12	CT	CT	CT	CT	CT	TK	TK	TK	ST	ST	ST	ST	ST	ST	
	/		18	MB	MB	MB	MB	MB	FK	FK	FK	FK	FK	gc	gc	gc	gc	
4 Jul	TK / gs	Activity - up ad lib	07-15	CT	CT	CT	CT	CT	TK	TK	TK	ST	ST	ST	ST	ST	ST	
	/		15-23	MB	MB	MB	MB	MB	FK	FK	FK	FK	FK	gc	gc	gc	gc	
	/		23-07	MW	MW	MW	MW	gT	gT	gT	gT	LT	LT	LT	LT	LT	LT	
8 Jul	TK / gs	Daily Weights	08					CT	CT	TK	TK	ST	ST	ST	ST	ST	ST	
	/																	
	/																	
	/																	
	/																	
	/																	
	/																	
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	/																	
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	/																	
	/																	
	/																	
	/																	

Solution:

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON MEDICATION)

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 4	5	6	7	8	9	10	11	12	13	14	15	16	17
4 Jul 81	TK / JS	Vital signs Q8 hrs	08	CT	CT	CT	CT	CT	TK	TK	TK	ST	ST	ST	ST	ST	ST
	/		16	MB	MB	MB	MB	MB	FK	FK	FK	FK	FK	JC	JC	JC	JC
	/		24	MW	MW	MW	MW	JT	JT	JT	JT	LT	LT	LT	LT	LT	LT
4 Jul 81	TK / JS	Diet Regular	07	CT	CT	CT	CT	CT	TK	TK	TK	ST	ST	ST	ST	ST	ST
	/		12	CT	CT	CT	CT	CT	TK	TK	TK	ST	ST	ST	ST	ST	ST
	/		18	MB	MB	MB	MB	MB	FK	FK	FK	FK	FK	JC	JC	JC	JC
4 Jul	TK / JS	Activity - up ad lib	07-15	CT	CT	CT	CT	CT	TK	TK	TK	ST	ST	ST	ST	ST	ST
	/		15-23	MB	MB	MB	MB	MB	FK	FK	FK	FK	FK	JC	JC	JC	JC
	/		23-07	MW	MW	MW	MW	JT	JT	JT	JT	LT	LT	LT	LT	LT	LT
8 Jul	TK / JS	Daily Weights	08					CT	CT	TK	TK	ST	ST	ST	ST	ST	ST
	/							RECOPIED ORDERS									
	/			18	19	20	21	22	23	24	25	26	27	28	29	30	31
4 Jul	JS	Vital Signs Q8 hrs	08														
	/		16														
	/		24														
4 Jul	JS	Diet Regular	07														
	/		12														
	/		18														
4 Jul	JS	Activity - Up Ad Lib	07-15														
	/		15-23														
	/		23-07														
8 Jul 81	JS	Daily Weights	07														
	/	Jane Doe Optronics															

59. Orders recopied prior to the Date Completed column being filled may be so indicated by bracketing existing initials and drawing a diagonal or single line across the remaining blocks and writing recopied/date/initials above the line.

No answer required.
Go on to the next page.

Clinical Record--Therapeutic Documentation Care Plan (Medications), DA Form 4678-1 (TEST)

(Medication Therapeutic Care Plan form)

60. The Medication Therapeutic Care Plan, printed on white paper, is used for doctor's medication orders and accompanying nursing orders pertaining to the administration of ordered medications. Medication orders will be transcribed from the Doctor's Orders for Medication form, DA Form 4256-1 (TEST). Nursing orders will be indicated by N.O./nurse's initials in the initialing column.

Doctor's medication orders and nursing orders pertaining to medications will be written on the

_____ _____

_____ _____

form.

Medication Therapeutic Care Plan

---

61. Codes identified on the form are used to document the patient's response to medication.

Patient response to medication is _____ by using codes identified on the form.

---

documented

---

61. Initials placed in the designated block indicate the medication has been administered.

When a medication has been administered, it is designated by placing _____ in the appropriate block.

---

initials

---

63. Initials and E indicate the medication was effective and achieved the desired results as specified in the original order. Further documentation is unnecessary.

If the medication was effective an ____ and your initials are all the _____ required.

E; documentation

---

64. Initials and I indicate the medication was ineffective. This code requires further explanation in the progress notes.

You indicate if the medication was ineffective with an ____ and your initials. Further documentation is _____.

I; necessary

---

65. Initials and Ø indicate the medication was not given or administered as ordered. This code requires additional notation on the Progress Notes regarding the reason for the subsequent omission and followup, as appropriate.

When a medication is not given, it must be noted on the _____ _____ and is indicated on the Medication Therapeutic Care Plan form with your initials and ____.

Progress Notes; Ø

---

66. Preparation: Enter all patient identification data as indicated.

Allergies: Specify the presence or absence of allergies. When known, indicate specific allergen.

Primary diagnosis: Enter admission diagnosis, or a corrected one as a definitive diagnosis is made or another condition develops. Add other diagnoses if they significantly affect the care to be given.

No answer required.
Go on to the next page.

Frames 67-76 concern the Recurring Medication section

67. The Recurring Medications, Dose, Frequency column is used for recurring drug administration when compliance with the order is repetitive and scheduled.

When compliance with the order is repetitive and scheduled, the _____ _____, _____, _____ column is used.

Recurring Medications, Dose, Frequency

---

68. Order Date: Enter the date the current order was written.

No answer required.
Go on to the next frame.

---

69. Initialing: The individual who transcribes the order must initial the specified block. A Registered Nurse must co-initial ALL orders at the earliest possible time regardless of who transcribes the orders.

All transcribed orders must be ____- _____ by a registered nurse.

---

co-initialed

---

70. Hour: List specific times vertically. Each space is a separate time of administration. When medications are ordered every 1 to 2 hours, two times may be entered in one block. Orders not time related, but pervasive throughout the shift are indicated by designating the inclusive times for each shift.

No answer required.
Go on to the next frame.

---

71. The top row of spaces indicates the day the medication is to be administered.

No answer required.
Go on to the next frame.

---

72. To verify compliance with the order, the responsible person will initial the block opposite each specific hour line and under the appropriate date column.

The responsible person will initial the block opposite each specific _____ _____ and under the appropriate date column.

---

hour line

---

73. Codes to indicate the effectiveness or ineffectiveness of the medication can be recorded in the same block with the responsible person's initials.

To record the _____ or _____ of the medications, codes and _____ of the responsible person can be used in the same block.

---

effectiveness; ineffectiveness; initials

---

74. Initials and E indicate the medication was effective and achieved the desired results. No additional documentation is required.

If the medication is effective, the only required documentation is your initials and an ____.

E

---

75. Initials and I indicate the medication was ineffective. If this code is used, further notation is required on the Progress Notes form.

Medication that is ineffective is recorded with your initials and an ____ with further notation on the _____ _____.

1, Progress Notes

76. The procedure for discontinuing orders on the Medication Therapeutic Care Plan form, DA FORM 4678-1 (Test), is identical to the procedure used for nonmedication orders on the Nonmedication Therapeutic Care Plan form.

When an order is discontinued a _____ line is drawn across the remaining blocks. A horizontal line is drawn across a single line order. _____/_____/_____/_____ are written above the line. _____ around the initials in the grid indicate no further use of the remaining blocks. USE OF _____ IS NOT AUTHORIZED.

diagonal; DC/date/time/initials; Brackets; HIGHLIGHTER

Frames 77-80 concern the Single Actions, Delayed Orders Preoperatives section

77. A delayed medication order is a Single Action order for medication which is not completed within the responsible Registered Nurse's tour of duty. It will be transcribed to the Single Actions, Delayed Orders, Preoperatives section of the Medication Therapeutic Care Plan form, DA FORM 4678-1 (TEST).

Delayed orders are transcribed to
the _____, _____
_____, _____
section of the

Single Actions, Delayed Orders,
Preoperatives

---

78. The original order date is recopied. The individual who transcribes the order must place initials in the space provided. A registered nurse must co-initial all orders at the earliest possible time regardless of who transcribed the order.

No answer required.
Go on to the next frame.

---

79. The complete delayed Single Action Order must be transcribed. Date and time the drug is to be administered is entered in the To Be Given column.

The date and time the drug is to be administered is transcribed to the

_____ _____
_____column.

To Be Given

---

80. After the medication has been administered, the date, time, and initials of the person administering the medication are written in the appropriate column. If the medication was omitted, initials appear in the designated block and an explanation is made on the Progress Notes form.

Further clarification on the _____ _____ form is made when a medication is not administered as ordered. Initials are recorded in the _____ _____/_____/ _____ column.

Progress Notes; Date Given/
Time/Initials

Frame 81-84 concern the PRN Medications section

81. The PRN Medications, Dose, Route, Frequency, Reason column is used when time of administration is not predictable.

No answer required.
Go on to the next frame.

---

82. The date the current order was written is recorded in the top portion of the Order/Expir Date column. An expiration date can be entered in the bottom portion. The individual transcribing the order must intial the specified block. A registered nurse must co-initial all orders at the earliest possible time, regardless of who transcribes the order.

No answer required.
Go on to the next frame.

83. The column identified as PRN Medication, Dose, Route, Reason and Frequency is for the recording of medication whose administration is not predictable. The medication to be administered, its dose, route, reason, and frequency are transcribed to the appropriate space.

No answer required.
Go on to the next frame.

84. When a PRN medication is administered, it is recorded in the Time/Date/Reason/ Effectiveness Code column. Each block indicates a separate action. Use of initials and the previously discussed E and I codes are appropriate.

No answer required.
Go on to the next page.

85. Example 1 of usage.

Situation: Dr. Jones has ordered the following medications for COL Adams who was admitted with a compound fracture of the left tibia:

CLINICAL RECORD DOCTOR'S ORDERS FOR MEDICATIONS

For use of this form see DA Ltr 40-85 the proponent agency is the Office of The Surgeon General

THE DOCTOR SHALL RECORD DATE TIME AND SIGN EACH SET OF ORDERS IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM INDICATE PROBLEM NUMBER

MEDICATIONS ONLY

PATIENT IDENTIFICATION	DATE OF ORDER / TIME OF ORDER	INITIALS: Time Noted and Transcribed	INITIALS: Time Single Order Done
Data from Patient ID Plate	18 July 84 / 1700 HOURS		
	Valium 5mg po BID		
	Ilgmerol 50mg Im Q4° prn pain		
	Seconal 100mg po prn sleep		
	John Doe MAJ MC		
	[Stamp]		
NURSING UNIT: 15A / ROOM NO: 850 / BED NO: 1			
PATIENT IDENTIFICATION	DATE OF ORDER / TIME OF ORDER ____ HOURS		
NURSING UNIT / ROOM NO / BED NO			
PATIENT IDENTIFICATION	DATE OF ORDER / TIME OF ORDER ____ HOURS		
NURSING UNIT / ROOM NO / BED NO			
PATIENT IDENTIFICATION	DATE OF ORDER / TIME OF ORDER ____ HOURS		
NURSING UNIT / ROOM NO / BED NO			

DA FORM 4256 1 (TEST) Edition of 1 Jul 77 is obsolete

Requirement: Transcribe the medication orders to the following portions of the Medication Therapeutic Care Plan form:

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN
(MEDICATIONS)

VERIFY BY INITIALING				INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION														
ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED														
	/																	
	/																	
	/																	
	/																	
	/																	
	/																	
	/																	
	/																	

THERAPEUTIC DOCUMENTATION CARE PLAN
(PRN MEDICATIONS)

Order/ Expir Date	Clerk / Nurse	PRN MEDICATION, DOSE, ROUTE, FREQUENCY, REASON	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE/REASON/INITIALS/EFFECTIVENESS CODE						
/	/								
/	/								
/	/								
/	/								

Solution:

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)																
VERIFY BY INITIALING			INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION														
ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY		DATE DISPENSED													
			HH	18	19	20	21	22	23	24	25	26	27	28	29	30	31
18 Jan	JDD	Valium 5mg po	06														
	/	6 & 12	12														
	/		18														
	/		24														
	/																
	/																
	/																
	/																
	/																
	/																

THERAPEUTIC DOCUMENTATION CARE PLAN (PRN MEDICATIONS)								
Order Expir Date	Clerk Nurse	PRN MEDICATION, DOSE, ROUTE, FREQUENCY, REASON	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE/REASON/INITIALS/EFFECTIVENESS CODE						
16 Jan 21 Jan	RDK / JD	Klonopin 50mg tab 6 & 12 pm pain							
16 Jan 21 Jan	RDK / JD	Klonopin 100mg po pm sleep							
/	/								
/	/								
/	/								

86. Example 2 of usage.

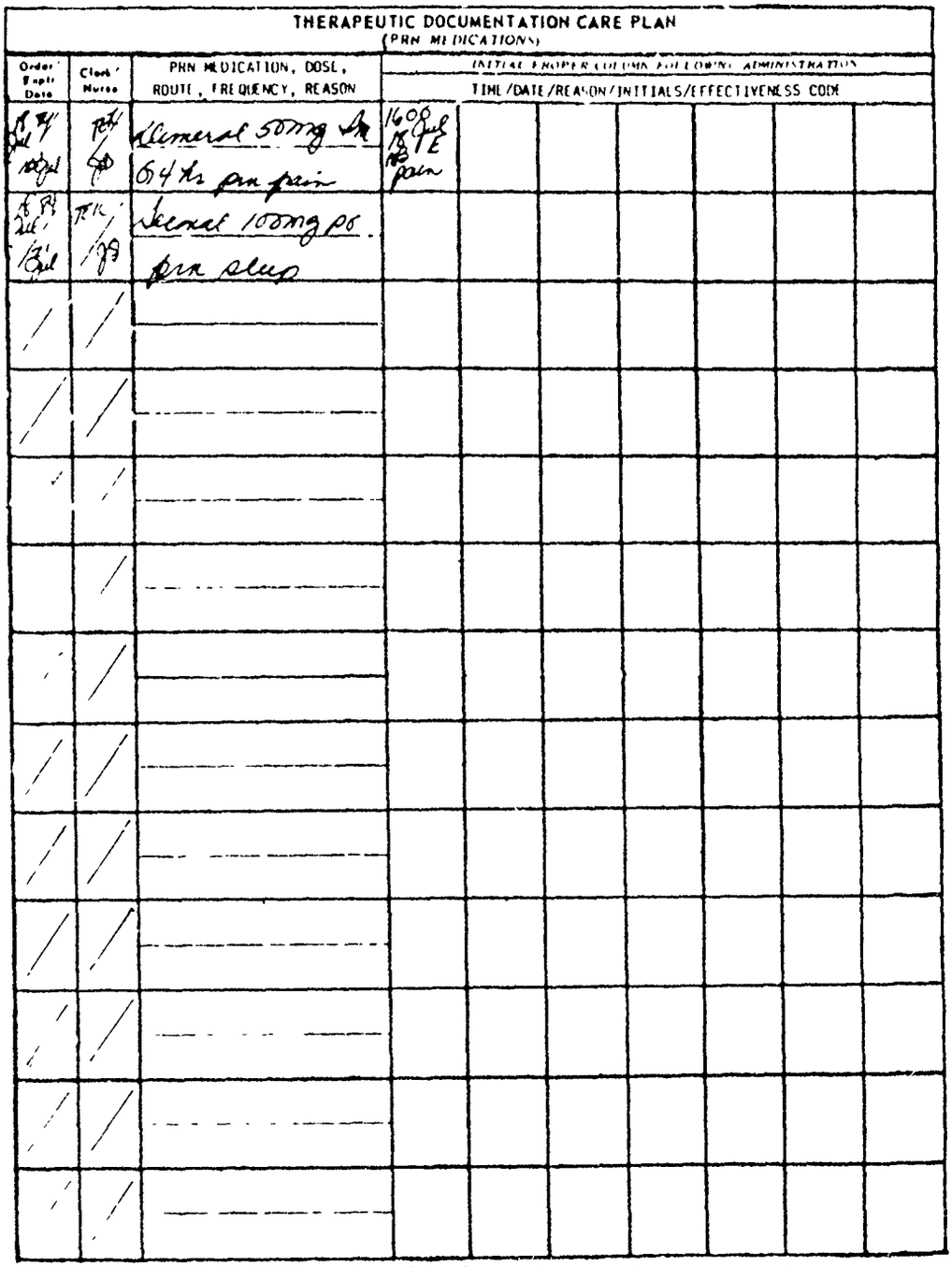
Situation: At 1600 you administered 50 mg of Dermeral IM to COL Adams. At 1645 COL Adams informed you his pain had subsided markedly.

Requirement: Accurately document the administration of Demerol and results on the Medication Therapeutic Care Plan form:

THERAPEUTIC DOCUMENTATION CARE PLAN
(PRN MEDICATIONS)

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, ROUTE, FREQUENCY, REASON	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE/REASON/INITIALS/EFFECTIVENESS CODE						
1/8 / /	TDL / JP	Demerol 50mg im q 4° prn pain							
1/8 8A / / 1/8	TDL / JP	Seconal 100mg po prn sleep							
/	/								
/	/								

Solution:



THERAPEUTIC DOCUMENTATION CARE PLAN
(PRN MEDICATIONS)

Order/ Expir. Date	Clerk/ Nurse	PRN MEDICATION, DOSE, ROUTE, FREQUENCY, REASON	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE/REASON/INITIALS/EFFECTIVENESS CODE						
		Klonopin 500mg q 8 hr 6 hrs pm pain	1600 pain						
		Klonopin 1000mg po pm sleep							

CODES: Initials only = indicate medication was administered
Initials and E = effective
Initials and I = ineffective *
Initials and ø - medication was not administered as ordered *

* See Nurse's note on SF 509

87. Example 3 of usage.

Situation: At 2300 COL Adams requested a sleeping pill. You gave him 100 mg of Seconal po as ordered. At 0030 COL Adams is wide awake. When asked, he denies pain and says: "I can't sleep; I have too much on my mind."

Requirement: Accurately record the administration of Seconal 100 mg po and results on the Medication Therapeutic Care Plan form:

18 Jul / 2100	PM / 2	Seconal 100mg po prn sleep							
/	/								
/	/								
/	/								
/	/								

CODES: Initials only = indicate medication was administered
Initials and E = effective
Initials and I = ineffective *
Initials and ø = medication was not administered as ordered *

* See Nurse's note on SF 509

Solution:

THERAPEUTIC DOCUMENTATION CARE PLAN
(PRN MEDICATIONS)

Order/ Progress Date	Clerk/ Nurse	PRN MEDICATION, DOSE, ROUTE, FREQUENCY, REASON	INITIAL IN UPPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE/REASON/INITIALS/EFFECTIVENESS CODE						
6 PM 26/ 10/91	PM / PP	Klonopin 500mg q 8h 6 Hrs pm pain	1600 10/26 PE pain						
6 PM 26/ 10/91	PM / PP	Klonopin 1000mg po pm sleep	2300 10/26 I pain						
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CODES: Initials only = indicate medication was administered
Initials and E = effective
Initials and I = ineffective *
Initials and ø = medication was not administered as ordered *

* See Nurse's note on SF 509

88. Example 4 of usage. Medication orders on the Medication Therapeutic Care Plan form are recopied when the Date Dispensed column is filled. A double line is drawn across the entire page below the last entry. Below the double line, or on a like blank form, Recopied Orders is written, the dates for coming days filled in, and each order still in effect, including the date of the original order, is recopied. Initialing procedures previously described for the Nonmedication Therapeutic Care Plan form will be used.

<u>Requirement</u>: Recopy the following orders:

CLINICAL RECORD — **THERAPEUTIC DOCUMENTATION CARE PLAN** *(MEDICATIONS)*

VERIFY BY INITIALING: ORDER DATE	VERIFY BY INITIALING: CLERK/NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION — DATE DISPENSED: 4	5	6	7	8	9	10	11	12	13	14	15	16	17
4 Jul 81	BS / FK	Ampicillin 250mg	06	BS	BS	B	BS	BS	TK	TK	TK	TK	BS	BS	BS	BS	BS
	/	po q 6 h	12	JC	JC	JC	JC	JC	LT	LT	LT	LT	MW	MW	MW	MW	MW
	/		18	CS	CS	CS	CS	BW	BW	BW	BW	BW	CS	CS	CS	CS	CS
	/		24	BS	BS	BS	BS	BS	TK	TK	TK	TK	BS	BS	BS	BS	BS
4 Jul 81	BS / B	$FeSO_4$ 325mg po	08	JC	JC	JC	JC	JC	LT	LT	LT	LT	MW	MW	MW	MW	MW
	/	qd															
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Solution:

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN
(MEDICATIONS)

ORDER DATE	CLERK NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 4	5	6	7	8	9	10	11	12	13	14	15	16	17
4 Jul 84	BS / FL	Ampicillin 250mg	06	BS	BS	BS	BS	BS	TL	TL	TL	TL	TL	BS	BS	BS	BS
	/	po 6 6 hr	12	CT	CT	CT	CT	CT	LT	LT	LT	LT	LT	MW	MW	MW	MW
	/		18	CS	CS	CS	CS	DM	DM	DM	DM	DM	DM	CS	CS	CS	CS
	/		24	CT	CT	CT	CT	CT	LT	LT	LT	LT	MW	MW	MW	MW	MW
5 Jul 84	BS / FL	FeSO4 325 mg po	08	CT	CT	CT	CT	LT	LT	LT	LT	LT	MW	MW	MW	MW	MW
	/	qd															
	/	Recapped Orders															
4 Jul 84	BS / CT	Ampicillin 250mg	06														
	/	po 6 6 hr	12														
	/		18														
	/		24														
5 Jul 84	TL / CT	FESO4 325mg po	08														
	/	qd															
	/	Jane Doe nay pm															
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Integration of the Medication and Nonmedication Doctor's Orders and Therapeutic Care Plan forms.

89. Example of integrated clincical record forms usage.

Situation: COL John Doe is admitted to your unit at 1700 on 14 July 198x with a diagnosis of cirrhosis of the liver. The following orders were written:

CLINICAL RECORD DOCTOR'S ORDERS FOR NON MEDICATIONS

For use of this form see DA Ltr 40-85 , the proponent agency is the Office of The Surgeon General

THE DOCTOR SHALL RECORD DATE TIME AND SIGN EACH SET OF ORDERS IF PROBLEM-ORIENTED MEDICAL RECORD SYSTEM INDICATE PROBLEM NUMBER

NON-MEDICATIONS ONLY

PATIENT IDENTIFICATION	DATE OF ORDER / TIME OF ORDER	INITIALS: Time Noted and Transcribed	INITIALS: Time Sing Order Don
Data from ID Plate	14 Jul 84 1700 HOURS		
	NPO except for PO medications		
	Vital signs Q 4h		
	SMA 12 in AM		
	Bedrest p Chest XRay		
NURSING UNIT / ROOM NO / BED NO	SMA 6 STAT		
	CBC STAT		
	PT, PTT STAT		
PATIENT IDENTIFICATION	DATE OF ORDER / TIME OF ORDER		
	Type & XMatch 6U Packed RBC's HOURS		
	Chest XRay tonight		
	PA & LAT Chest in AM		
	CBC Q 0600,1400,2400 hrs		
	Daily abdominal girth 0600		
	I&O		
NURSING UNIT / ROOM NO / BED NO	John Jones MAJ MC [S from P]		

CLINICAL RECORD DOCTOR'S ORDERS FOR MEDICATIONS

For use of this form see DA Ltr 40-85 , the proponent agency is the Office of The Surgeon General

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS IF PROBLEM-ORIENTED MEDICAL RECORD SYSTEM INDICATE PROBLEM NUMBER

MEDICATIONS ONLY

PATIENT IDENTIFICATION	DATE OF ORDER / TIME OF ORDER	INITIALS: Time Noted and Transcribed	INITIALS: Time Single Order Done
Data from ID Plate	14 Jul 84 1700 HOURS		
	Lasix 10 mg IM STAT		
	Aldactone 50mg po QID		
	Thiamine 50mg po QID		
	John Jones MAJ MC [STAMP]		
NURSING UNIT / ROOM NO / BED NO			

All blood work was done and STAT medication administered at 1730 hours; recurring medications were started at 1800. Oral QID medications are given at 0600-1200-1800-2200 on your unit. Ward clerks work during the day shift.

Requirement: Account for the doctor's orders and use the column for Single Action Orders as appropriate:

CLINICAL RECORD - DOCTOR'S ORDERS FOR NON MEDICATIONS

For use of this form, see DA Ltr 40-85 , the proponent agency is the Office of The Surgeon General

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM INDICATE PROBLEM NUMBER

NON-MEDICATIONS ONLY

PATIENT IDENTIFICATION	NURSING UNIT	ROOM NO	BED NO	DATE OF ORDER / TIME OF ORDER	INITIALS: Time Noted and Transcribed	INITIALS: Time Single Order Done
Data from ID Plate				14 Jul 84 1700 HOURS		
				NPO except for PO medications		
				Vital signs Q 4h		
				SMA 12 in AM		
				Bedrest p Chest XRay		
				SMA 6 STAT		
				CBC STAT		
				PT, PTT STAT		
PATIENT IDENTIFICATION	NURSING UNIT	ROOM NO	BED NO	DATE OF ORDER / TIME OF ORDER		
				Type & XMatch 6U Packed RBC's HOURS		
				Chest XRay tonight		
				PA & LAT Chest in AM		
				CBC Q 0600,1400,2400 hrs		
				Daily abdominal girth 0600		
				I&O		
				John Jones MAJ MC (STAMP)		

CLINICAL RECORD DOCTOR'S ORDERS FOR MEDICATIONS

For use of this form, see DA Ltr 40-85 , the proponent agency is the Office of The Surgeon General

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS IF PROBLEM-ORIENTED MEDICAL RECORD SYSTEM INDICATE PROBLEM NUMBER

MEDICATIONS ONLY

PATIENT IDENTIFICATION	NURSING UNIT	ROOM NO	BED NO.	DATE OF ORDER / TIME OF ORDER	INITIALS: Time Noted and Transcribed	INITIALS: Time Single Order Done
Data from ID Plate				14 Jul 84 1700 HOURS		
				Lasix 10 mg IM STAT		
				Aldactone 50mg po QID		
				Thiamine 50mg po QID		
				John Jones Maj MC [STAMP]		

Solution:

CLINICAL RECORD DOCTOR'S ORDERS FOR NON-MEDICATIONS

For use of this form see DA Ltr 40-85 , the proponent agency is the Office of The Surgeon General

THE DOCTOR SHALL RECORD DATE TIME AND SIGN EACH SET OF ORDERS IF PROBLEM-ORIENTED MEDICAL RECORD SYSTEM INDICATE PROBLEM NUMBER

NON-MEDICATIONS ONLY

PATIENT IDENTIFICATION	DATE OF ORDER / TIME OF ORDER	INITIALS: Time Noted and Transcribed	INITIALS: Time Sing Order Do
Data from ID Plate	14 Jul 84 1700 HOURS		
	NPO except for PO medications		
	Vital signs Q 4h	1800MB	
	SMA 12 in AM		
	Bedrest p Chest XRay		
	SMA 6 STAT		1730MB
NURSING UNIT / ROOM NO / BED NO	CBC STAT		1730MB
	PT, PTT STAT		1730MB
PATIENT IDENTIFICATION	DATE OF ORDER / TIME OF ORDER		
	Type & XMatch 6U Packed RBC's HOURS		1730MB
	Chest XRay tonight		1730MB
	PA & LAT Chest in AM		
	CBC Q 0600,1400,2400 hrs	1800MB	
	Daily abdominal girth 0600		
	I&O		
NURSING UNIT / ROOM NO / BED NO	John Jones MAJ MC [STAMP]		

CLINICAL RECORD DOCTOR'S ORDERS FOR MEDICATIONS

For use of this form see DA Ltr 40-85 , the proponent agency is the Office of The Surgeon General

THE DOCTOR SHALL RECORD DATE TIME AND SIGN EACH SET OF ORDERS IF PROBLEM-ORIENTED MEDICAL RECORD SYSTEM INDICATE PROBLEM NUMBER

MEDICATIONS ONLY

PATIENT IDENTIFICATION	DATE OF ORDER / TIME OF ORDER	INITIALS: Time Noted and Transcribed	INITIALS: Time Single Order Done
Data from ID Plate	14 Jul 84 1700 HOURS		
	Lasix 10 mg IM STAT		1755MB
	Aldactone 50mg po QID	1800MB	
	Thiamine 50mg po QID	1800MB	
	John Jones MAJ MC [STAMP]		
NURSING UNIT / ROOM NO / BED NO			

Requirement: Transfer COL Doe's recurring medications to the Medication Therapeutic Care Plan form. Account for medications administered:

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*
For use of this form, see AR 40-407;
the proponent agency is the Office of The Surgeon General

VERIFY BY INITIALING			INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION															
ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED														
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Solution:

CLINICAL RECORD		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)															
VERIFY BY INITIALING				INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION													
				DATE DISPENSED													
ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	14	15	16	17	18	19	20	21	22	23	24	25	26	27
8Jul 84	TCX/RB	Aldactone 50mg	10														
	/	po qid	14														
	/		18	RB													
	/		22														
14Jul84	TCX/RB	Kleanex 50mg	10														
	/	po qid	14														
	/		18	RB													
	/		22														
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Requirement: Transfer COL Doe's recurring nonmedication orders to the Nonmedication Therapeutic Care Plan form. Account for completed actions:

CLINICAL RECORD		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)															
VERIFY BY INITIALING				INITIAL PROPER COLUMN FOLLOWING COMPLETION													
				DATE COMPLETED													
ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR														
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Solution:

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON MEDICATION)

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 14	15	16	17	18	19	20	21	22	23	24	25	26	27
14 Jul 84	TCK/MB	NPO except for Meds	07-15														
	/		15-23	MB													
	/		23-07														
14 Jul 84	TCK/MB	Vital Signs	10														
	/	q 4 hr	14														
	/		18	MB													
	/		22														
	/		02														
	/		06														
14 Jul 84	TCK/MB	CBC	06														
	/		14														
	/		21														
14 Jul 84	TCK/MB	Daily abdominal girth	06														
	/																
14 Jul 84	TCK/MB	Lyte	07-15														
	/		15-23	MB													
	/		23-07														
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(CONTINUE ON REVERSE)

Requirement: Transfer the nonmedication Single Action, Delayed Orders to the Nonmedication Therapeutic Care Plan form. Account for completed actions:

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)* For use of this form see DA Letter XXX-85, the proponent agency is the Office of the Surgeon General		
Order Date	Clerk Nurse	SINGLE ACTIONS, DELAYED ORDERS	TO BE DONE	COMPLETED
	/			
	/			
	/			
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	/			
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Solution:

Verify by Initialing		THERAPEUTIC DOC. ENTATION CARE PLAN (NON MEDICATION) For use of this form see DA Letter XXX 85, the proponent agency is the Office of the Surgeon General		
Order Date	Clerk Nurse	SINGLE ACTIONS, DELAYED ORDERS	TO BE DONE	COMPLETED
4/4/84	TEK/RB	PA & Lat Chest in AM	0600 15 Apr 84	
4/4/84	TEK/RB	SMA-12 in AM	0600 15 Apr 84	
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ALLERGIES YES NO | PRIMARY DIAGNOSIS

PATIENT IDENTIFICATION

CODES:

Initials only = Indicates completion of order
Initials and + = Satisfactory/within normal limits
Initials and ø = Unsatisfactory/Not observed/ Omitted *

* See Nurse's note on SF 509

DA FORM 4677-1 (TEST)

Medical Record--Nursing Discharge Summary, DA FORM 3888-5 (TEST)

(Nursing Discharge Summary from)

90. The Nursing Discharge Summary form, is used to summarize the patient's health status/special instructions upon discharge. This nursing discharge summary brings together all pertinent patient information found throughout the chart, and ensures that all audit criteria have been met. It is considered the discharge nursing note and suffices for an otherwise lengthy discharge note on the Progress Notes form. All the notation required on the Progress Note form after completion of the Nursing Discharge Summary form is "Patient discharged, See DA Form 3888-5 (TEST)," or words to that effect.

The Nursing Discharge Summary is a three part form: The original copy becomes part of the patient's inpatient treatment record; the second copy is reviewed with the patient and retained by him or her or the family; the third copy is placed in the outpatient treatment record.

Entries may be made by nursing personnel. However, regardless of what information is recorded, and by whom, the registered nurse is ultimately responsible for ensuring the accuracy and completeness of the entries, and for reviewing the instructions with the patient or significant other prior to discharge.

All areas and blanks are completed with pertinent, factual information written in terms the patient can understand. The recorder's initials, followed by a yes or no are placed in all blocks related to the patient's understanding of instructions and information.

Situation: MAJ. Fred Smith is a 42-year old male who was admitted to the medical ward following 1 week of Serial Blood Pressures which were taken on an outpatient basis. His admission BP was 170/98. The primary diagnosis was Essential Hypertension. The hospital course was uneventful, all lab tests were within normal limits, and the patient responded well to treatment of Catapres and a 1500 calorie low sodium diet. During his hospital stay, MAJ Smith and his wife were instructed in how to take a blood pressure, specifics of a 1500 calorie low sodium diet, and his medication regimen. The patient is presently 40 pounds overweight. MAJ Smith and his family express interest and concern in the control and maintenance of a normal blood pressure and are willing to work with the professional staff to alleviate this medical problem. MAJ Smith is discharged to duty after 8 days of hospitalization. He has an appointment for a followup visit in the medical clinic in 1 week. His discharge BP is 130/80.

Requirement: Complete the following Nursing Discharge Summary form using the above information.

MEDICAL RECORD – NURSING DISCHARGE SUMMARY

For use of this form see DA Ltr 40 85 , the proponent agency is the Office of The Surgeon General

Date/Time.	Discharged to ☐ Home Other (Specify) Mode ☐ Ambulatory Other (Specify)	Accompanied by

I ACTIVITY ☐ No Restrictions Limitations (Specify) _____

_____ Patient and/or Significant Other (S O.) communicates knowledge and understanding of activity limitations

II. DIET. ☐ No Dietary Restrictions If special, identify _____

_____ Patient/S O. communicates understanding of dietary restrictions.

III MEDICATIONS. ☐ No Medication Required

Name of Medication	Dosage	Frequency of Medication	Special Instructions

_____ Patient and/or Significant Other (S O) communicates knowledge and understanding of name, dosage, frequency and special instructions.

IV. TREATMENTS/CARE:

Instructions Given.	Patient/S O Observed Demonstration (Date)	Patient/S O Returned Demonstration (Date)

Equipment/Supplies (Specify)

V. FOLLOWUP You should be seen in _____ clinic in _____ (time period).

Important Telephone Numbers Emergency Room _____ Central Appointment _____ Ward _____ Clinic _____

Appointment ☐ No appointment needed

☐ An appointment is to be made by the patient at _____

☐ An appointment has been made at _____ clinic on _____ at _____ hours.

☐ Referral Initiated

_____ Patient/S O communicates understanding of followup instructions

VI. PATIENT'S CONDITION (Health Status relative to Nursing Care Plan) _____

Signature (Registered Nurse)	Additional Information
Patient Identification	

DA Form 3888-5 (TEST)

Solution:

MEDICAL RECORD - NURSING DISCHARGE SUMMARY

For use of this form, see DA Ltr 40-85; the proponent agency is the Office of The Surgeon General

Date/Time: 15 June 84 0900 | Discharged to: X Home; Other (Specify) | Accompanied by: wife

Mode: X Ambulatory; Other (Specify)

I ACTIVITY — X No Restrictions; Limitations (Specify) ____

Yes MB (Patient and/or Significant Other (SO) communicates knowledge and understanding of activity limitations

II DIET — No Dietary Restrictions; If special identify 500 Calorie low sodium diet

Yes MB (Patient/SO communicates understanding of dietary restrictions

III MEDICATIONS — No Medication Required

Name of Medication	Dosage	Frequency of Medication	Special Instructions
Catapres	0.1mg	Twice a day	Take 1 tablet in morning + one at bedtime

Yes Patient and/or Significant Other (SO) communicates knowledge and understanding of name, dosage frequency and special instructions.

IV TREATMENTS/CARE

Instructions Given	Patient/SO Observed Demonstration (Date)	Patient/SO Returned Demonstration (Date)
Taking own BP-Wt & instruments & recording results	13 June 84	13-14 June 84

Equipment/Supplies (Specify)

V FOLLOWUP You should be seen in Medical clinic in 1 wk (time period)

Important Telephone Numbers: Emergency Room 1234 Central Appointment 5678 Ward 9011 Clinic 12134

Appointment — No appointment needed

An appointment is to be made by the patient at

X An appointment has been made at Medical clinic on 22 June at 1000 hours.

X Referral Initiated Wife by dietician for diet instr. Will make F/u appt in CAS 1 wk

Yes MB (Patient/SO communicates understanding of followup instructions

VI PATIENT'S CONDITION (Health Status relative to Nursing Care Plan) Physical condition essentially normal except for obesity and hypertension. Pt & wife express intense concern in control and maintenance of high BP. Pt & wife instruction in control will assist with problems.

Signature (Registered Nurse): Margaret Brown Cpt AN

Patient Identification: data from ID Plate

Additional Information: Admit BP 170/98; D/C BP 130/80

DA Form 3888-5 (TEST)

PART IV

INTEGRATED RECORD
PROGRESS NOTES

91. Clinical Record-Nursing Notes (SF 510) (Nursing Notes form). This form will not be used for the duration of the study period. All narrative nursing notations will be recorded on the Progress Notes form.

No answer required.
Go on to the next frame.

---

92. In accordance with AR 40-66, para. 7-11b, "Progress notes will describe chronologically the clinical course of the patient. They should reflect any change in condition and results of treatment...."

In accordance with AR _____, para. 7-11b, "Progress notes will describe chronologically the clinical course of the patient. They should reflect any change in condition and results of treatment..."

40-66

---

93. For the period of the Clinical Nursing Records Study, an integrated approach will be taken towards the writing of progress notes. All health team members, including nursing personnel, will record on the same form in a chronological sequence. The nursing progress notes begin with an admission note, unless one was written on the Nursing History and Assessment form when the patient was admitted.

For the period of the Clinical Nursing Records Study, an integrated approach will be taken towards the writing of progress notes. ____ health team members, including _____ _____, will record on the same form in a _____ _____. The nursing progress notes begin with an admission note, unless one was written on the Nursing History and Assessment form DA FORM 3888-2 (Test) when the patient was admitted.

All; nursing personnel; chronological sequence

---

94. Nursing personnel will continue to use the Medication and Nonmedication Therapeutic Care Plan forms, and other approved flowsheets to indicate routine activities or therapy. Specific notations of the patient's response will be written in the progress notes. For example, nursing may do a history and assessment, identifying problems, discharge considerations, and nursing goals, but afterwards, depending on the prescribed circumstances as further outlined, followup notes are made on the Progress Notes form.

Nursing personnel will continue to use the Medication and Nonmedication Therapeutic Care Plan forms and other approved flowsheets to indicate routine activities or therapy. Specific notations of the _____ _____ will be written on the _____ _____ form. For example, nursing may do a history and assessment, identifying problems, discharge considerations and nursing goals, but afterwards, followup notes are made on the _____ _____form.

---

patient's response; Progress Notes;
Progress Notes

---

95. The patient's record will show progress or a lack of progress which would indicate: 1) Objective evidence of treatment and procedures is documented; 2) medical orders are followed and appropriate care is given by the respective departments; and 3) observations which describe and answer questions regarding what the patient does, how it is done, and how the patient looks are documented when pertinent. In addition, interactions with the patient or subjective statements of the patient which describe what the patient says, how it is said, and how he or she feels are documented when pertinent.

The patient's record will show _____ or a _____ _____, which would indicate: 1) Objective evidence of treatment and procedures is documented; 2) medical orders are followed and appropriate care is given by the respective departments; 3) observations which describe and answer questions regarding what the patient does, how it is done, and how the patient looks are documented when _____. In addition,

interactions with the patient or subjective statements of the patient which describe what the patient says, how it is said, and how the patient feels are documented when pertinent.

---

progress; lack of progress; pertinent

---

96. All nursing personnel are authorized to chart on the Progress Notes form during the test period. However, documentation, in any form, by other than the registered nurse, does not absolve the registered nurse (i.e., head nurse, charge nurse, team leader, etc.) of the responsibility for professional supervision and review of nursing care.

_____ nursing personnel are authorized to chart on the SF 509 during the test period. However, documentation, in any form, by other than the registered nurse, does not absolve the registered nurse of the _____ for professional supervision and review of nursing care.

All; responsibility

Go on to the next page.

97. The registered nurse must assess the individual nursing provider's skill level for documentation. The head nurse, or designee, must consider the quality of the progress notes written by the paraprofessional or registered nurse to be meeting professional standards and medical/ legal requirements. Additional training may be done on an individual basis between the head nurse and staff members, by the nursing education and training service at the MTF, or as otherwise designated by the chief nurse. The head nurse will periodically review progress notes written by staff members.

No answer required.
Go on to the next frame.

---

98. Frequency of nursing charting will be dictated by the patient's response and the professional responsibility and judgement of those authorized to chart on the form. Charting will be based primarily on exceptions to the expected course of the patient's treatment.

Frequency of charting will be dictated by the patient's response and the professional responsibility and judgement of those authorized to chart on the form. Charting will be based primarily on _____ to the _____ of the patient's treatment.

---

exceptions;
expected course

---

99. What the recorder determines to be pertinent is related to his or her nursing judgement. Several points are emphasized:

a. Documentation is made of patient transportation to and from the operating room, recovery room, treatment off the MTF premises, or transfer to another unit. It is not necessary to chart routine successful transportation to various treatment areas such as PT, X-Ray, etc.

b. Some Single Action Orders will require an assessment of the intervention's efficacy. If such an order has not been transcribed to either the Medication or Nonmedication Therapeutic Care Plan form, the assessment must appear on the Progress Notes form.

c. Negative statements should be avoided unless they serve a useful purpose. Without a new statement, the previously documented status exists, since charting is based on "exceptions to the expected course of the patient's treatment."

d. Generalized judgemental statements without supporting facts on which such judgements were made are to be avoided.

e. Record concisely; be specific as the situation is seen; correlate what is seen with what is known.

What the recorder determines to be pertinent is related to nursing judgement. Several points are emphasized:

a. Documentation is made of transportation to and from the _____ _____, _____ _____, _____ _____ _____ premises, and transfer to _____ _____.

operating room, recovery room,
off the MTF;
another unit.

b. The assessment of the efficacy of a Single Action Order not transcribed to the Medication or Nonmedication Therapeutic Care Plans is to appear on the _____ _____form.

Progress Notes

c. Negative statements should be _____ unless they serve a useful purpose. Without a new statement, the _____ _____ _____exists.

avoided;
previously documented status

d. Generalized, judgemental statements without _____ _____ on which such judgements were made are to be avoided.

supporting facts

e. Record _____; be _____
as the situation is seen.

---

concisely; specific

---

100. The majority of the incidental and routine charting related to the efficacy of nursing interventions and other patient responses will be done on the Medication and Nonmedication Therapeutic Care Plan forms using the codes printed on each sheet. However, if a less than desired result or response is noted, a problem has arisen, and the subsequent notation by the nursing personnel on the Progress Notes will be problem oriented. This does not preclude the writer from making a notation on a patient even if everything has gone according to plan. For example, a note may be necessary to add continuity or to provide a succinct summary of a shift's activity .

The majority of the incidental or routine charting of the efficacy of nursing interventions and other patient responses will be done on the _____ ___ _____ _____ _____ _____ forms. However, if a less than desired result or response is noted, it will be charted on the _____ _____ form.

Medication and Nonmedication
Therapeutic Care Plan; Progress Notes

---

101. Notations on the Progress Notes form may be diary style or problem oriented. No format is mandated. However, components of the nursing process should be evident in the progress notes written by nursing personnel.

Notations on the Progress Notes form may be _____ or _____ _____. No format is mandated. However, components of the nursing process should be evident in the progress notes written by nursing personnel.

---

diary style; problem oriented

---

102. The following mechanics for writing a note on the Progress Notes form are to be followed by nursing personnel:

a. All notations are to be made in black or blue-black ink. Standard abbreviations as noted in appendix B of AR 40-66 will be used.

b. Each notation is to be preceded with the date and time of entry, and the nursing care plan problem(s) to be reflected in the progress note (e.g., 6 July 1984, 0800, NCP #2,3). The problem may be listed by number or name.

c. All entries will close with the signature, rank, and title of the writer. A line is to be drawn to complete unused space as necessary.

d. LATE entries (entries out of chronological order) may be made by first noting the date and time of the current notation, followed by an indication that this is a recording of an event out-of-sequence. No attempt

is to be made to squeeze in this data to fit the sequence of notations.

e. A mistake is not erased. A line is drawn through the error and marked error in recording followed by a notation of the correct information.

The following mechanics for writing the note are to be kept in mind:

a. All notations are to be made in _____ or _____ ink.

_____

black; blue-black

_____

b. Each notation is to be preceeded with date and time of entry and the _____ _____ _____ _____(s) to be reflected in the progress note.

_____

nursing care plan problem

_____

c. All entries will close with _____,_____ and _____ of the writer.

_____

signature; rank; title

_____

d. LATE entries may be made by first noting the date and time of the current notation, followed by an indication that this is a recording of an event ____ __ _____.
No attempt is to be made to _____ in this data to fit the sequence of notations.

---

out-of-sequence;
squeeze

---

e. A mistake is _____ _____.

---

not erased

---

* * * * * * * * * * * * * *

One final note:

The preceding forms and governing instructions have been developed in accordance with DA Regulations, the AMEDD Standards of Nursing Practice and nursing service standards published by the Joint Commission on Accreditation of Hospitals (JCAH). Documentation of patient care has become an essential component of daily nursing activities. In reality, it can become a cumbersome, redundant, and inflexible exercise, frustrating even the most proficient, dedicated, and organized care provider. The test forms were designed to reduce redundancy and fragmentation of the clinical record. Yet, it is the overall quality of a patient's record which will convey a true picture of the hospital stay. The forms are merely the basis for organizing the information. Quality flows from the pen of the writer!

* * * * * * * * * * * * * *

THIS IS THE END OF THE PROGRAMMED TEXT

APPENDIX F

Methodology Phase III

HSHN-H
1 August 1985

INFORMATION PAPER

SUBJECT: The Clinical Nursing Records Study

ISSUE: To describe a study regarding nursing documentation conducted by the USA Health Care Studies and Clinical Investigation Activity (HCSCIA), Ft Sam Houston, TX. Prepared for Commanders and headquarters' staffs at test sites.

FACTS:

1. In recent years general dissatisfaction has been verbalized within the Army Nurse Corps regarding inpatient nursing documentation. There has been an overwhelming number of requests for overprints and exceptions to policy. A 1981 ad hoc committee for clinical nursing records proposed revisions and recommended testing of revised forms. The study was assigned to HCSCIA as part of the FY 84 AMEDD Study Program. Emphasis was expanded to examine all inpatient forms currently in use at MTFs. The Study Director is COL Marian Walls, ANC, formerly Senior Staff Officer, Nursing Division, HQ HSC, currently, Chief, Department of Nursing, Brooke Army Medical Center. Co-investigators are MAJ Martha Bell, ANC and LTC Terry R. Misener, ANC, Nursing Methods Analysts, HCSCIA.

2. A worldwide survey of Army nursing personnel identified documentation problems. A working group of ANC officers was formed to identify possible changes within the scope of JCAH requirements, ARs, and medical-legal considerations. Representatives from HSC DCCS, PAD, and JAG served as advisors. In addition, proposed changes were coordinated with OTSG PAD, OTSG Publications, and DA TAG to insure that "test" forms are considered parts of the permanent inpatient record. Concomitantly, proposed changes have been reviewed by the JCAH. OTSG Consultants were briefed regarding the study effort and have concurred.

3. The authority for the test is HQDA Letter 40-85-4 "Clinical Nursing Records Study-Test Forms". Five revised and three new forms (Appendix 1) will be tested. SF 509 Progress Notes will be used by nursing personnel during the test. Test forms are authorized for use only at designated sites. The forms will be phased in over a month on all nursing units at each test site, and used for an additional three months. HQDA Letter 40-85-4 authorizes use of the test forms for two years; hence, facilities will have the option to continue using the forms after the testing period. Printing costs will be absorbed by DA; one year's quantity has been ordered to preclude local reproduction of forms and guidelines.

4. Four MTFs (FAMC, and the hospitals at Fts Jackson, Campbell, and Polk) will participate in the study. Hospital staffs will be oriented to the test by project personnel from local Departments of Nursing. Site coordination will be completed through project officers appointed by local Chief Nurses. Your Project Officer is _____.

MAJ Bell/471-4880

APPENDIX 1

Clinical Nursing Records Study

Test Forms

REVISED FORMS

DA Form 3888-2 (TEST) Medical Record--Nursing History and Assessment
(revision of DA 3888)

DA Form 3888-4 (TEST) Medical Record--Nursing Care Plan
(revision of DA 3888-1)

DA Form 4256-1 (TEST) Clinical Record--Doctor's Orders for Medications
(revision of DA 4256)

DA Form 4677-1 (TEST) Clinical Record--Therapeutic Documentation Care Plan for Nonmedications
(revision of DA 4677)

DA Form 4678-1 (TEST) Clinical Record--Therapeutic Documentation Care Plan for Medications
(revision of DA 4678)

NEW FORMS

DA Form 3888-3 (TEST) Medical Record--Nursing History and Assessment, continued

DA Form 3888-5 (TEST) Medical Record--Nursing Discharge Summary
(NOTE: a multiple copy form; copies designed to be included in the inpatient and outpatient treatment records and provided as a record of discharge instructions for patient's home use.)

DA Form 4256-2 (TEST) Clinical Record--Doctor's Orders for Nonmedications

HSHN-H
1 August 1985

INFORMATION PAPER

SUBJECT: The Clinical Nursing Records Study

ISSUE: To describe a study regarding nursing documentation conducted by the USA Health Care Studies and Clinical Investigation Activity (HCSCIA), Ft Sam Houston, TX. Prepared for Department of Nursing personnel at test sites.

FACTS:

1. In recent years general dissatisfaction has been verbalized within the Army Nurse Corps regarding inpatient nursing documentation. There has been an overwhelming number of requests for overprints and exceptions to policy. A 1981 ad hoc committee for clinical nursing records proposed revisions and recommended testing of revised forms. The study was assigned to HCSCIA as part of the FY 84 AMEDD Study Program. Emphasis was expanded to examine all inpatient forms currently in use at MTFs. The Study Director is COL Marian Walls, ANC, formerly Senior Staff Officer, Nursing Division, HQ HSC, currently Chief, Department of Nursing, Brooke Army Medical Center. Co-investigators are MAJ Martha Bell, ANC and LTC Terry R. Misener, ANC, Nursing Methods Analysts, HCSCIA.

2. A worldwide survey of Army nursing personnel identified documentation problems. A working group of ANC officers was formed to identify possible changes within the scope of JCAH requirements, Army Regulations, and medical-legal considerations. Representatives from HQ HSC Patient Administration Division, Judge Advocate General, and Deputy Chief of Staff for Clinical Services served as advisors. "Test" forms will be part of the permanent inpatient record. Proposed changes and guidelines have been reviewed by the JCAH. OTSG Consultants have been briefed regarding the study effort and have concurred. Commanders of test sites have agreed to testing of forms at their respective facilities.

3. Five revised and three new forms (Appendix 1) will be tested. Revisions involve the nursing history, assessment, and care plan formats (DA Forms 3888 and 3888-1); the use of a coding system on revised Therapeutic Documentation Care Plans (DA Forms 4677 and 4678) to indicate efficacy of intervention; and the separation of nonmedication from medication orders on the physician's order sheets (DA Form 4256). Chart dividers will be provided to separate medication from nonmedication orders, with necessary "pull tabs" to enable care providers to "flag" newly written orders. Transcription of certain orders to revised Therapeutic Documentation sheets will no longer be required because of the format of the order sheets. New forms to be introduced are a nursing discharge summary and nursing history/assessment continuation form. Nursing personnel will use the SF 509 Progress Notes rather than SF 510 Nursing Notes during the test period.

4. All Department of Nursing personnel and other hospital staff will be oriented to test forms and guidelines by study personnel from local

Departments of Nursing. The forms will be phased in over a month on all nursing units at each test site and used for an additional three months. Following the testing period, personnel will be asked to assess various aspects of the forms and guidelines. Facilities will have the option to continue using the forms after the testing period.

5. Four medical treatment facilities (Fitzsimons Army Medical Center, and the hospitals at FTs Jackson, Campbell and Polk) will participate in the study effort. Test forms are authorized for use ONLY at designated sites. Project officers from the Departments of Nursing have been appointed by local Chief Nurses. Questions or issues concerning the test forms are to be directed to your Project Officer who is _____.

MAJ Bell/471-4880

APPENDIX 1

Clinical Nursing Records Study

Test Forms

REVISED FORMS

DA Form 3888-2 (TEST) Medical Record--Nursing History and Assessment
(revision of DA 3888)

DA Form 3888-4 (TEST) Medical Record--Nursing Care Plan
(revision of DA 3888-1)

DA Form 4256-1 (TEST) Clinical Record--Doctor's Orders for Medications
(revision of DA 4256)

DA Form 4677-1 (TEST) Clinical Record--Therapeutic Documentation Care Plan for Nonmedications
(revision of DA 4677)

DA Form 4678-1 (TEST) Clinical Record--Therapeutic Documentation Care Plan for Medications
(revision of DA 4678)

NEW FORMS

DA Form 3888-3 (TEST) Medical Record--Nursing History and Assessment, continued

DA Form 3888-5 (TEST) Medical Record--Nursing Discharge Summary
(NOTE: a multiple copy form; copies designed to be included in the inpatient and outpatient treatment records and provided as a record of discharge instructions for patient's home use.)

DA Form 4256-2 (TEST) Clinical Record--Doctor's Orders for Nonmedications

HSHN-H
1 August 1985

INFORMATION PAPER

SUBJECT: The Clinical Nursing Records Study

ISSUE: To describe a study regarding nursing documentation conducted by the USA Health Care Studies and Clinical Investigation Activity (HCSCIA), Ft Sam Houston, TX. Prepared for MC, AMSC, and MSC officers at test sites.

FACTS:

1. In recent years general dissatisfaction has been verbalized within the Army Nurse Corps regarding inpatient nursing documentation. There has been an overwhelming number of requests for overprints and exceptions to policy. A 1981 ad hoc committee for clinical nursing records proposed revisions and recommended testing of revised forms. The study was assigned to HCSCIA as part of the FY 84 AMEDD Study Program Emphasis was expanded to examine all inpatient forms currently in use at MTFs.

2. A worldwide survey of Army nursing personnel identified documentation problems. A working group of ANC officers was formed to identify possible changes within the scope of JCAH requirements, Army Regulations, and medical-legal considerations. Representatives from HQ HSC Patient Administration Division, Judge Advocate General, and Deputy Chief of Staff for Clinical Services served as advisors. Proposed changes and guidelines were reviewed by the JCAH. OTSG Consultants were briefed regarding the study effort and have concurred. Commanders of all test sites agreed to testing of forms at their respective facilities.

3. Five revised and three new forms will be tested. Revisions involve the nursing history, assessment and care plan formats (DA Forms 3888 and 3888-1); the use of a coding system on revised Therapeutic Documentation Care Plans (DA Forms 4677 and 4678) to indicate efficacy of intervention; and the separation of nonmedication from medication orders on the physician's order sheets (DA Form 4256). Chart dividers will be provided to separate medication from nonmedication orders, with necessary "pull tabs" to enable care providers to "flag" newly written orders. New forms to be introduced are a nursing discharge summary and nursing history/assessment continuation form. Nursing personnel will use the SF 509 Progress Notes rather than SF 510 Nursing Notes during the test period. "Test" forms will be part of the permanent inpatient record.

4. Hospital staffs will be oriented to test forms and guidelines by project personnel from local Departments of Nursing. The forms will be phased in over a month on all nursing units at each test site and used for an additional three months. Following the testing period, personnel will be asked to assess various aspects of the forms and guidelines. Facilities will have the option to continue using the forms after the testing period.

5. Four medical treatment facilities (Fitzsimons Army Medical Center, and the hospitals at FTs Jackson, Campbell and Polk) will participate in the study effort. Project officers from the Departments of Nursing have been appointed by local Chief Nurses. Questions or issues concerning the test forms are to be directed to your Project Officer who is _____.

MAJ Bell/471-4880

HSHN-H
1 August 1985

INFORMATION PAPER

SUBJECT: The Clinical Nursing Records Study

ISSUE: To describe a study regarding nursing documentation conducted by the USA Health Care Studies and Clinical Investigation Activity (HCSCIA), Ft Sam Houston, TX. Prepared for Patient Administration Division personnel at test sites.

FACTS:

1. In recent years general dissatisfaction has been verbalized within the Army Nurse Corps regarding inpatient nursing documentation. There has been an overwhelming number of requests for overprints and exceptions to policy. A 1981 ad hoc committee for clinical nursing records proposed revisions and recommended testing of revised forms. The study was assigned to HCSCIA as part of the FY 84 AMEDD Study Program. Emphasis was expanded to examine all inpatient forms currently in use at MTFs.

2. A worldwide survey of Army nursing personnel identified documentation problems. A working group of ANC officers was formed to identify possible changes within the scope of JCAH requirements, ARs, and medical-legal considerations. Representatives from the HQ HSC PAD, JAG, and Deputy Chief of Staff for Clinical Services served as advisors. In addition, proposed changes have been coordinated with OTSG PAD, OTSG Publications, and DA TAG to insure that "test" forms are considered parts of the permanent inpatient record. Proposed changes and guidelines were reviewed by the JCAH. OTSG Consultants were briefed regarding the study effort and have concurred. Commanders of test sites have agreed to allow testing of forms at their respective facilities.

3. The authority for the test is HQDA Letter 40-85-4 "Clinical Nursing Records Study-Test Forms". Five revised and three new forms (Appendix 1) will be tested. Forms are authorized for use ONLY at test sites. Nursing personnel will use SF 509 Progress notes to record narrative notations usually found on the SF 510 Nursing Notes. SF 510 will not be used during the period of the test.

4. Hospital staffs will be oriented by study personnel from local Departments of Nursing. The forms will be phased in over a month on all nursing units at each test site, and used for an additional three months. HQDA Letter 40-85-4 authorizes use of the test forms for two years; hence, facilities will have the option to continue using the forms after the testing period. One year's quantitiy has been ordered to preclude local reproduction of forms or guidelines.

5. Four medical treatment facilities (Fitzsimons Army Medical Center, and the hospitals at FTs Jackson, Campbell and Polk) will participate in the study. The costs of printing all forms and accompanying guidelines will be

absorbed by DA. Guidelines will be provided to medical records personnel at test sites. Project officers from the Departments of Nursing have been appointed by local Chief Nurses. Questions or issues concerning the test forms are to be directed to your Project Officer who is _____.

MAJ Bell/471-4880

APPENDIX 1

Clinical Nursing Records Study

Test Forms

REVISED FORMS

DA Form 3888-2 (TEST) Medical Record--Nursing History and Assessment
(revision of DA 3888)

DA Form 3888-4 (TEST# Medical Record--Nursing Care Plan
(revision of DA 3888-1)

DA Form 4256-1 (TEST) Clinical Record--Doctor's Orders for Medications
(revision of DA 4256)

DA Form 4677-1 (TEST) Clinical Record--Therapeutic Documentation Care Plan for Nonmedications
(revision of DA 4677)

DA Form 4678-1 (TEST) Clinical Record--Therapeutic Documentation Care Plan for Medications
(revision of DA 4678)

NEW FORMS

DA Form 3888-3 (TEST) Medical Record--Nursing History and Assessment, continued

DA Form 3888-5 (TEST) Medical Record--Nursing Discharge Summary
(NOTE: a multiple copy form; copies designed to be included in the inpatient and outpatient treatment records and provided as a record of discharge instructions for patient's home use.)

DA Form 4256-2 (TEST) Clinical Record--Doctor's Orders for Nonmedications

APPENDIX G

Findings Phase III

Test Site Project Officer Reports

Clinical Nursing Records Study Final Report

Fitzsimons Army Medical Center

Aurora, Colorado

Major Timothy P. Williams

15 January 1987

Introduction

This report is being provided at the request of the U S Army Health Care Studies and Clinical Investigation Activity, Fort Sam Houston, Texas, by the project officer, MAJ Timothy P. Williams, Army Nurse Corps. Fitzsimons Army Medical Center is located in Aurora, Colorado and currently has 526 functional beds. The population that Fitzsimons serves is an eleven-state, tri-service region, with the majority of patients served arriving at this facility through the air evacuation system provided by the U S Air Force. Fitzsimons, being a medical center, is a teaching facility. Currently, there are 284 staff physicians that are credentialed. These physicians are categorized as follows: 118 active duty, 48 civilian, 22 contract, and 70 consultants. We have 21 dentists on active duty at Fitzsimons, 9 civilian dentists, and 2 consultants. Nurses show 184 active duty Army Nurse Corps officers, 123 civilian nurses, and 13 contract nurses. Those total do not include the paraprofessional staff consisting of LPNs, 91As, 91Bs, 91Cs, and nursing assistants. The total number of paraprofessional staff currently is 381 personnel.

Fitzsimons Army Medical Center is a multi-disciplinary facility providing services which include the traditional elements found in Department of Medicine -- allergy, immunology, cardiology, endocrinology, hematology/oncology, gastroenterology, general medicine, infectious disease, rheumatology, internal medicine, pulmonary disease, dermatology, neurology, and an emergency medical team. The Department of Surgery consists of otolaryngology, neurosurgery, general surgery, orthopedics, plastic surgery, thoracic surgery, and urology. Fitzsimons Army Medical Center also has a Department of Psychiatry, a Clinical Investigation Service, a Physical Medicine and Rehabilitation Service, Department of Obstetrics and Gynecology, Department of Pathology, Department of Primary Care, and Community Medicine, Department of Radiology, and a Department of Pediatrics.

The actual test of the clinical nursing records was conducted at Fitzsimons from the period November 1985 through March 1986. During that time period, no other tests, data base information or additional training was occurring. The breakdown of the several months that the test was conducted is a follows: During the month of November 1985, the entire nursing and medical staff and all other ancillary staff that had access to the inpatient medical records were trained. Because of size, it took the entire month of November to accomplish this task. This will be addressed in more detail later in the report. During the month of December 1985, the new forms were slowly integrated into the inpatient medical records. This process will also be outlined in greater detail later in the report. The actual test window began January 1986 and ran through March of that year. At that time (March 1986), it was the decision of the Commander of Fitzsimons, Brigadier General Philip K. Russell, that the use of the test documents be continued for the next two-year period.

Implementation

The command at Fitzsimons Army Medical Center was first notified of their potential selection as a test site for the Clinical Nursing Records Study in May 1984. A letter was received from the Army Health Care Studies and Clinical Investigation Activity Commander, LTC Fred A. Cecere. At that time, the Commander of the Health Care Studies and Clinical Investigation Activity

had asked for input as to the cooperation of Fitzsimons Army Medical Center as a potential test site and also the need to designate a project officer. The response that came at that time was that Fitzsimons Army Medical Center would indeed be willing to participate in this particular project and LTC Rosalie Lord was designated as the project officer. A final determination was made in June 1984 that Fitzsimons would be considered as the medical center test site for this project, and communication began to flow requesting background data about the facility. Briefing of the command group at Fitzsimons was conducted by the Assistant Chief Nurse, COL Naldene Borg and LTC Rosalie Lord. The decision was made by BG Russell that he would support this test should FAMC be selected as a test site. BG Russell had no particular concerns or questions, and agreed to full cooperation.

Included at enclosure 1 is the Memorandum for Record presented by LTC Lord to the command group with reference to the Clinical Nursing Records Study. At that time we were also told that the other three test sites would be Fort Campbell, Fort Polk, and Fort Jackson; these would be the only four test sites due to funding constraints. Due to the numerous revisions of the test forms and drafting of new forms, the Clinical Nursing Records Study did experience several delays. The delays were not those at Fitzsimons, but those with logistics in trying to coordinate the revisions of the new forms at a higher level. A pre-site selection information report was provided to LTC Martha Bell by LTC Lord outlining the functional beds and the approximate monthly usage of forms at Fitzsimons (see enclosure 2). With the permanent change of station move of LTC Lord in February 1985, a new project officer was assigned, MAJ Timothy P. Williams. When MAJ Williams assumed the responsibilities of project officer, the forms had already been ordered for Fitzsimons in a volume which LTC Lord had approximated would suffice for one year's use. Quantities supplied can be found at enclosure 3. With the large volume of forms coming in to Fitzsimons, immediate coordination had to be made for logistic control of these documents.

Logistics

Forms Management at Fitzsimons Army Medical Center was tasked with the receipt of these forms, their inprocessing, and accountability. Two problems arose from this particular situation. First, the area designated for storage of forms at Fitzsimons could not handle the volume of forms being sent. Therefore, an alternative site had to be obtained for storage. Secondly, because the forms were in the test mode, there were problems with accountability using current logging systems. A new system was developed by our Forms Manager to keep track of the test forms and they were separated from all other forms currently in the system.

Distribution of the forms was coordinated by the project officer with the cooperation of the Chief Wardmaster of the hospital, the service NCOICs, and the wardmasters of each nursing unit. The loading dock at the back of Fitzsimons was used for distribution of the forms. A special detail provided by the brigade headquarters at Fitzsimons brought the forms from the storage site. The project officer logged all of the forms by number and distributed them over a four-hour period to all of the wardmasters and NCOICs in the facility. Each wardmaster and NCOIC was responsible for obtaining a one-month supply of the forms for their particular activity. Prior coordination had been made by the project officer with the individuals to ascertain what this number

would be so that an adequate amount of forms could be transported to the loading dock area. At this time, inpatient wardmasters also received the Carstens dividers based on the total number of chart backs currently being used in their particular unit. Once again, there was a problem with the number of dividers that were supplied. A shortage of approximately 50-75 of the dividers was realized. The wardmasters cooperated and shared the dividers supplied and an emergency request was made to obtain the additional number needed. With implementation occurring over a holiday period, the low census allowed the test to continue until additional chart dividers were received. By January when the census started to rise again, the additional chart dividers needed were on site.

Training

It was identified immediately that due to the size of Fitzsimons, additional trainers would be required. Two additional trainers were identified. Both were staff nurses within the Department of Nursing, Fitzsimons Army Medical Center, and were selected because of their ability to verbalize and an interest that they had shown in other documentation projects at Fitzsimons. As was discovered during the actual training time frame, due to the fact that these two individuals were staff nurses, often times it meant that they were pulled from their staff duties or they had to come in on days off or off scheduled times in order to conduct training sessions. The dedication that these two individuals showed during the training should be underscored and was certainly a factor in the success of this study at Fitzsimons.

Strategies for training included a verbal presentation and also overheads were used as audio-visual aids. Formal presentations were held in the auditorium in the main hospital. At enclosure 4 is the schedule of classes for the mandatory briefings held at Fitzsimons. Training was made mandatory upon realizing that all personnel having access to inpatient records should be readily informed of the changes in medical records being studied. Training was set up to incorporate morning, afternoon, and evening time frames to allow for all shift work personnel to attend one of these briefings in the most convenient manner for them. Personnel were notified using the chain of command within Department of Nursing through the service supervisors, the head nurses, down to all the staff personnel. Ancillary personnel were notified by the project officer by contacting their particular department chiefs and informing them of the necessity for this training.

Training also included project officer briefings at Form Sam Houston where the project officer and the two additional trainers were given an in-depth background as to the Clinical Nursing Records project and strategies for training and implementation. This was conducted prior to our November 1985 mandatory briefings.

Implementation of Forms

Due to a delay in printing and also a printing error, the implementation of the project at Fitzsimons was nearly delayed. Permission was given to proceed with the project. Implementation began in December 1985, and the staff was alerted to the errors that were present.

The strategy that was used to incorporate the new forms in to the system is as follows: All patients that were admitted to Fitzsimons beginning 1 December were admitted using the new form documents. Patients that were in-house patients on 1 December 1985, the old forms were used until their discharge. If a patient's hospitalization was continued after 31 December 1985, their charts were converted to the new forms. On 1 January 1986, all patient charts contained the new chart documents. This particular strategy of phasing in the forms seemed to work well and no particular problems were encountered. Of concern was the problem that was faced during the implementation phase with the lack of knowledge and cooperation from the medical staff in the use of the divided Doctors Order Sheet, i.e., one Doctors Order Sheet for medications and a separate Doctors Order Sheet for non-medication orders. Through discussions with the Commander at Fitzsimons Army Medical Center and the various department chiefs, this particular problem was quickly resolved.

Because of the size of Fitzsimons, it also should be pointed out that many of the units, being very specific in the patient clientele which they serve, had many overprinted forms already in use. With the immediate implementation of new form documents, the old documents with overprinting were no longer available. The particular overprinting problems encountered were, first, that the Forms Management personnel could not handle the volume of requests for immediate overprinting. Secondly, the Therapeutic Documentation Care Plans (TDs) for both medication and non-medication presented a problem for overprinting as they did not fit into the printing machinery. At Fitzsimons, fortunately the particular type of printing machine could be modified so that these documents were eventually hand-fed through the press and overprinted. In the interim, several computerized typewriters were used to generate these documents. This problem was overcome, although it did initially present an additional workload for the nursing and clerical staff.

During the implementation phase and during the entire test window, unusual occurrences were monitored carefully. There were no unusual occurrences generated by the use of the new chart documents.

During implementation, much cooperation had to be gained from not only the staff using the forms in direct patient care, but also ancillary staff, such as our Directorate of Patient Administration. All charts, upon discharge of the patient, are reviewed for completeness and accuracy. Checklist, used by PAO personnel, had to be modified to include the new documentation forms (see enclosure 5). Records were returned to the respective department chiefs whenever nursing documentation was not complete or it was inaccurate. Appreciation is expressed to the Directorate of Patient Administration for ingenuity and imagination in developing a modified checklist to include the new nursing documents.

During the course of the implementation and test phase, December 1985 through March 1986, updates were sent to the staff from the project officer as reminders for the proper use and completion of forms. This project officer is also the Quality Assurance Coordinator for the Department of Nursing, therefore chart auditing was done on a daily basis to make certain that the staff was in compliance with the new rules and regulations governing the use of the new chart documents. These particular newsletters served a great purpose in reminding the staff of the proper use of the chart forms and reinforced their continued cooperation.

The test ended in March 1986. Before the end of the test, on 17 March 1986, an information paper was compiled by the project officer and provided to the Chief, Department of Nursing to help guide in the decision to continue or not to continue to use the new forms. The advantages that were identified are as follows:

a. there was a decrease in the amount of narrative charting by nursing staff, with an increase in the quality of charting.

b. there was an improvement in the completion of inpatient nursing documentation,

c. positive comments with apparent increase in staff morale were received from all nursing staff, and there was a general acceptance by the medical staff of the nursing documentation and the use of the Doctors Order Sheets, and

d. it improved the efficiency within the Pharmacy Service with the processing of new medication orders. Pharmacy Service is holding these statistics.

The disadvantages of the new forms were:

a. there was a slow process for overprinting; that problem was resolved at FAMC,

b. printing errors in the test forms still existed, however, new forms had been requested, and

c. the division of the Doctors Order Sheets; there was still a small minority of medical staff that objected to this particular part of the test. This information was provided to the Commanding General, and on 31 March 1986, the decision was made to continue to use the new chart documents for the next two years.

When the test itself had concluded, several problems had arisen, logistically, with obtaining new supplies of forms. Emergency printing requests had to be submitted in March and April 1986 to continue to have an adequate supply of the Doctors Order Sheets for medication. This order could not be filled before our supply had been exhausted. The project officer worked carefully with Reproduction and Forms Management personnel to locally reproduce these forms on an emergency basis to supply the needs of the hospital. This did present an added expense on the already strained budget of the Forms Management activity at Fitzsimons. When problems had been resolved at the DA level, the new forms did arrive to replace those that we had to reproduce locally.

The second major logistics problem that occurred at the conclusion of the actual test is that we began running out of all of the forms. The original figures that had been provided by LTC Lord for an actual one-year supply of the forms was exhausted during the first four months, i.e., the one month of implementation, and the three month test. In retrospect, a more careful analysis need be made of actual usage of forms, keeping in mind that the new TD Sheets are used to a greater degree than the old TD Sheets were, and also that the Doctors Order Sheets for medications are used to a greater degree than the Doctors Order Sheets for non-medications.

Assistance visits from the Health Care Studies and Clinical Investigation Activity were made by LTC Bell and Pat Twist during the month of December when we had initially begun the implementation and use of these forms. These on-site visits were a great help to the staff at Fitzsimons and also afforded the staff an opportunity to ask questions directly of the principal investigator. I would recommend in future implementation strategies that on-site visits be made early in the test so that during these times of maximum confusion, the experts in the use and development of these forms will be on-hand to answer questions that the staff may have. This on-site visit included ward rounds by the principal investigator which also afforded opportunities for the head nurses to ask their questions directly to LTC Bell.

Evaluation

The evaluation of the Clinical Nursing Records Study was conducted at Fitzsimons with the cooperation of the Health Care Studies and Clinical Investigation team. The questionnaires were provided by the Health Care Studies Division and arrived at Fitzsimons for distribution. Distribution was conducted by the project officer. The NCOICs and wardmasters of each clinical nursing unit were asked to represent their inpatient units. In addition, each of the departments were asked to send a representative to a meeting to collect the questionnaires that they would need for their respective areas. An information DF was sent to all of the activities involved in the test explaining the need for accuracy in the distribution, completion, and collection of these questionnaires. The project officer coordinated the distribution and the turn-in of the evaluation questionnaire as well.

Evaluation was conducted over a five-day period. The forms were distributed on the first day, and it was asked that they be returned by the fourth day. All questionnaires were to be returned whether or not they were completed. On the fourth day, the project officer with the assistance of the Assistant Chief, Department of Nursing at Fitzsimons collected all of the outstanding questionnaires and logged them in based on the numbers that had been provided to the specific departments. Packaging had been furnished by the Health Care Studies activity, day five, the questionnaires were returned to Fort Sam Houston. Instructions for completion of the evaluations were written by the project officer and were provided to all the department chiefs and chief of ancillary departments that were involved in the test. Participants in the study were divided into four groups for evaluation purposes: The nursing staff, the medical staff, the ancillary staff that worked in the inpatient setting, and the administrative staff. Each point of contact for these four separate groups was asked to check off the names of all the individuals as they handed out the evaluation form to them. Distribution began on 23 July, with a return on 25 July. The questionnaires were then returned to the project officer sealed in the coded envelope. As the envelopes were returned, the names were again checked off. The project officer was careful to make certain that the exact number of questionnaires distributed was maintained and that the exact number of questionnaires returned were accounted for.

The majority of the staff provided excellent input as to their opinions for the use, modification and implementation of the test documents. The staff at Fitzsimons felt that the new chart documents provided a much greater resource for accurately assessing and narrating the documentation in the inpatient setting. The medical staff cooperated with the use of the two Doctors Order Sheets during the test, however, the majority of the medical

staff during the evaluation phase felt that it still was an inconvenience, but agreed to continue to cooperate.

Recommendations

Recommendations are as follows:

1. That more than one project officer be identified when the forms are implemented. Consideration should be given to the size of the facility, the time that was required for educating the staff, the logistical coordination and monitoring activities necessary to ensure that care is not compromised.

2. I would like to outline each form individually as to recommendations from this facility. Only minor modifications would be needed with any of these forms.

a. DA 3888-2, Nursing History and Assessment form: No recommendations noted.

b. DA 3888-3, the Nursing History and Assessment continuation sheet: No recommendations noted.

c. DA 3888-4, the Nursing Care Plan: The recommendation from the nursing staff was overwhelming that the list of the nursing diagnoses at the end of the form was not an all-inclusive list, and because of its everchanging nature, should be eliminated. This space could be used to increase the size of the Nursing Care Plan and the section to write discharge considerations.

d. DA 3888-4: No recommendations.

e. DA 4677-1: Therapeutic Documentation Care Plan for Non-medications and DA 4678-1, Therapeutic Documentation Care Plan for Medication:

(a) The first recommendation is that the sequential order of these forms coincide with the sequential order of the Doctors Order Forms. The DA 4258-1 Doctors Order Sheet for Medications and the first of the Nursing TD Sheets for Medication be the DA 4677-1. As it is now, just the opposite is true.

(b) Other recommendations for the DA 4877-1 and the DA 4878-1: From this facility we had no problems with overprinting once the necessary arrangements were worked out with the FAMC Forms Management activity. In the critical care setting, it was noted that because of the bi-fold nature of this form, it became impossible for the staff nurses to use this particular form on a standardized clipboard.

f. Doctors Order Sheets, DA 4258-1 and DA 4258-2: No recommendations are made.

g. Clinical Nursing Records Study Guidelines: They were well written and have been reprinted numerous times at FAMC for distribution to new personnel. The programmed instruction for the Clinical Nursing Record Guide has also been beneficial. An additional recommendation would be that in future implementation, a form-by-form handout be given to individuals during the instructional phase so that they can follow on a document in front of them,

as well as following on an overhead. Many times, particularly at Fitzsimons with the size of the audiences that we had, personnel in the back of the room were not able to see the fine print on the forms used with overhead.

Conclusion

In conclusion, not many recommendations for change are made. The elements that caused the greatest problems were outside the control of the investigation team and the test site project officers. Planning was started for educational implementation before the actual arrival of the test documents; however, planning should not be done until the documents arrive and have been screened for printing errors. A team would be necessary for implementation, particularly at the larger MEDDACs and MEDCENs when worldwide distribution occurs. This has been a learning experience for this project officer and the learning continues as additional personnel and newly assigned personnel arrive at the facility.

HSHG-NS 9 November 1984

MEMORANDUM FOR RECORD

SUBJECT: Clinical Nursing Records Study

1. PURPOSE:

a. In recent years, much controversy has surfaced regarding all nursing documentation in US Army Treatment Facilities. General dissatisfaction with current documentation procedures has been verbalized within the Army Nurse Corps. The volume of requests for exception to policy and requests for overprints have demonstrated the magnitude of this concern. Pursuant to TSG FY 84 Army Medical Department Study Program, under AR 5-5, the Clinical Nursing Records Study will examine all inpatient nursing documentation required by the Army and the JCAH. The study proposes to determine inpatient nursing documentation needs and to field test the revised forms.

b. In order to insure validity of alternative documentation methods, it will be necessary to study facilities of various sizes and population served. Several MTFs are being contacted. Eight sites will be selected for final testing. Because of the size and locale of Fitzsimons Army Medical Center, it has been recommended by HQ, HSC as one of the possible sites for data collection. The study will entail a complete test of nursing documentation by removing selected DA and Standard Forms from facilities for a 90 day period, and substituting DA test forms.

2. POSITIVE REASONS FOR CONDUCTING STUDY AT FAMC:

a. Large, teaching facility with a variety of services (medicine, surgery, OB/GYN, etc.), thus providing a large sample from which to collect data for validating the study.

b. Target population for doing the study is good due to variety of participants; various ranks, various educational background, and levels of expertise.

c. Enthusiasm of the participants. Nursing personnel are dissatisfied with the present forms and are enthusiastic to try other types (revision or new) forms.

3. POSITIVE REASONS FOR DOING THE STUDY:

a. Present forms are inadequate:

(1) Two sided requiring a turning of papers from side to side particularly TDCP DA 4678 leading to medications being overlooked or delayed in administration.

(2) Quality of paper: Paper is very flimsy, tears easily, and becomes dislodged from binders and charts.

b. New Forms will decrease replication of documentation.

c. Standardization of forms at all MTFs:

(1) Reduce the need to overprint "other" forms.

(2) Reduce confusion in being introduced to new forms when reassigned to another MTF.

d. Integrated use of progress note:

(1) Will facilitate reading of nurse's notes by physicians, reading of physician's notes by nurses which will lend itself to continuity of patient's care.

(2) More awareness of patient's progress and plan of care including discharge considerations.

4. NEGATIVE ASPECTS OF THE STUDY:

a. Doctor's order sheet DA 4256:

(1) Time involved in writing orders on two different charts, i.e., Medication, Nonmedications.

(2) Greater number of pages in patient's record thus increasing possibility of papers becoming misplaced, lost, etc.

b. Integrated progress notes SF 509:

(1) Difficulty in getting patient's record to document on progress note.

(a) Doctor writing orders, notes.

(b) Nurse writing notes.

(c) Chart with patient in another department.

(2) Documentation being out of time sequence.

(a) Factors as mentioned in 4a(1), above.

(b) Delay in getting documentation done in timely manner due to other activities by both doctors and nurses.

5. NEED TO BE ACCOMPLISHED FOR THE STUDY:

a. New concept of doctor and nursing personnel documenting on same note (SF 509):

HSHG-NS 9 November 1984
SUBJECT: Clinical Nursing Records Study

(1) Require increased judgment and assessment skills by nursing personnel so that information documented is related to patient's progress; this may require reteaching of what and how to document.

(2) Head Nurses and Wardmasters to be more involved in instructing, evaluating, and follow-up of documentation.

(3) More Thorough audit of charts by Head Nurses for adequate and appropriate documentation.

ROSALIE N. LORD
LTC, ANC
Quality Assurance Coordinator

Clinical Nursing Records Study

Pre-Site Selection Information

SITE: Fitzsimons Army Medical Center

PROJECT OFFICER: MAJ(P) Rosalie Lord (AUTOVON): 943-8783

CHIEF NURSE: COL Teryl Miller (AUTOVON): 943-4118

Present Bed Capacity: 627, but only 506 operational beds.

Clinical Nursing Units (name, specialty and size, e.g., "Ward 1A, Female Medicine, 20 beds").

See attached sheet for information on clinical nursing units.

APPROX NUMBER OF HOSPITAL DISCHARGES PER MONTH: 1330

APPROXIMATE MONTHLY USAGE OF

DA Form 3888	4,500	
3888-1	5,850	
4256	26,450	
4677	16,900	
4678	14,500	
4700	242	without overprinting
STANDARD FORM 509	38,350	
510	25,950	

Clinical Nursing Units

2 East A	General Medicine	31 beds
2 East B	General Medicine	21 beds
2 West A	General Medicine	24 beds
2 West B	General Medicine	33 beds
3 East	Pediatrics	36 beds
3 West	General Surgery (male)	43 beds
SICU		9 beds
MICU		7 beds
CCU		7 beds
4 West Surg	General Surgery (female)	27 beds
4 West Ortho	Orthopedic (female)	26 beds
5 East	Orthopedic (male)	50 beds
5 West Ortho	Orthopedic & Plastic	32 beds
5 West Neuro	Neuro Surgery	18 beds
6 East	GYN/Oncology	28 beds
6 North	Labor and Delivery	7 beds
6 West	Obstetrics	17 beds
NBN		23 bassinets
NICU		7 bassinets
7 East	Urology	18 beds
7 West	Thoracic Surgery	16 beds
609	Psychiatry	30 beds

QA INFORMATION: What is the mechanism used at your facility for performing "audits" of nursing records? (Who does this, how often, integrated committees, etc.?) Please enclose copies of forms.

Nursing Process Audit - done monthly by professional nurses assigned to nursing units.
Nurse Practitioners - done quarterly.
OPC - done monthly by nursing personnel assigned to OPC.
Emergency Room - done monthly by professional staff.
Nursing Audit Committee - retrospective and generic audits every month, criteria is based on nursing process, policies and procedures. Criteria is different each month.
Operating Room - done monthly, criteria is different each month.

ARE ALL INPATIENT UNITS ON "UNIT DOSE?"

IF NO, which ones are NOT?

All units are on unit dose except CCU and Psychiatry.

NURSING EDUCATION AND TRAINING SERVICE: Describe resources (e.g., is the Chief NETS "dual hatted"; capabilities to support DON wide education program; secretarial support, etc.)?

NETS is itself very busy planning, developing and implementing educational programs for the professional and paraprofessional level, DON wide educational programs as well as continuing education programs for FAMC and the community. FAMC has an active reserve training program which is coordinated though NETS, this requires a great deal of NETS time. NETS does have its own secretarial support which requires 100% time of that secretary for work by NETS.

SECRETARIAL RESOURCES AVAILABLE TO PROJECT OFFICER

Secretarial support available to project officer is the clerk typist for the DON. This individual does typing for the Assistant Chief, Department of Nursing, all DON section chiefs, Infection Control Nurse, Chief, CMS and QA nurse. She is responsible for typing all reports, committee meeting minutes, policies, procedures, letters of appreciation and an array of other miscellaneous items.

MISCELLANEOUS REMARKS

Please attach copies of any modifications of DA Forms (DA approved or NOT!) used by nursing units at your facility. Include a cover sheet in the following format listing all overprinted forms:

CLINICAL AREA	MEDDAC/MEDCEN #	OVERPRINT ON	TITLE	DATED
(Example) PEDS	42F	DA 4700	Neuro Checks	24 May 84

Printing Requirements
Clinical Nursing Records Study

FORMS

DA Form 3888-2 (TEST) Medical Record -- Nursing History and Assessment
DA Form 3888-3 (TEST) Medical Record -- Nursing History and Assessment (Continued)
DA Form 3888-4 (TEST) Medical Record -- Nursing Care Plan
DA Form 3888-5 (TEST) Medical Record -- Nursing Discharge Summary
DA Form 4256-1 (TEST) Clinical Record -- Doctor's Orders for Medications
DA Form 4256-2 (TEST) Clinical Record -- Doctor's Orders for Nonmedications
DA Form 4677-1 (TEST) Clinical Record -- Therapeutic Documentation Care Plan for Nonmedications
DA Form 4678-1 (TEST) Clinical Record -- Therapeutic Documentation Care Plan for Medications

Quantity

TEST SITES	Cut Sheets			Snap Outs			Folders		SITE TOTALS
	3888-2	3888-3	3888-4	3888-5	4256-1	4256-2	4677-1	4678-1	
FAMC	28,000	28,000	32,500	30,000	34,000	34,000	50,000	47,000	283,500
CMPBl.	9,000	9,000	9,000	10,000	23,000	23,000	23,000	21,000	127,000
JKSN	16,000	16,000	20,000	19,000	17,000	17,000	27,000	23,000	155,000
POLK	8,000	8,000	12,500	10,000	25,000	25,000	13,000	13,000	114,000
HCSCIA	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	8,000
OTSG	20	20	20	20	20	20	20	20	160
TOTALS	62,020	62,020	75,020	70,020	100,020	100,020	114,020	105,020	687,660

GUIDELINES and PROGRAMMED TEXT

"Clinical Nursing Records Study Form Guidelines" (Guidelines)

"Clinical Nursing Records Study: A Programmed Instruction" (PT)

QUANTITY

SITE	Guidelines	PT
FAMC	1000	1000
CMPBL	450	450
JKSN	450	450
POLK	400	400
HCSCIA	150	150
OTSG	20	20
TOTALS	1570	1570

MANDATORY BRIEFING

on

Clinical Nursing Records Study

WHO SHOULD ATTEND?

ALL FAMC personnel directly involved with patient care and personnel in Patient Records.

DATE	TIME	LOCATION
12 November	0730-1030 hours	Bushnell Auditorium
13 November	0730-1030 hours	Bushnell Auditorium
14 November	1130-1430 hours	Bushnell Auditorium
15 November	1130-1430 hours	Bushnell Auditorium
18 November	1130-1430 hours	Bushnell Auditorium
19 November	0730-1030 hours	Bushnell Auditorium
20 November	0730-1030 hours	Bushnell Auditorium
21 November	1130-1430 hours	3W Classroom
22 November	1130-1430 hours	Bushnell Auditorium
25 November	0730-1030 hours	Bushnell Auditorium
25 November	1130-1430 hours	Bushnell Auditorium
26 November	1200-1500 hours	3W Classroom
27 November	0730-1030 hours	Bushnell Auditorium

*This class is mandatory

*Attendance will be taken

PROFESSIONAL STAFF DOCUMENTATION REMINDER

	Date Record Returned
	Second Request
Attending Physician	Discharge Date
Medical Record Technician	Nursing Unit/Ward

Do Not Remove This Form Or Colored Tabs From The Inpatient Treatment Record

ITR COVER SHEET (DA Form 3647)
( ) Review
( ) Sign/Countersign
( ) Initial
( ) Added Diagnosis Including Infection/Complication

NARRATIVE SUMMARY (SF 502)
( ) Sign/Countersign
( ) Missing

ABBREVIATED SUMMARY (SF 539)
( ) Sign/Countersign
( ) Missing

HISTORY/PHYSICAL (SF 504,505, 506)
( ) Sign/Countersign
( ) Missing

PROGRESS NOTES (SF 509)
( ) Sign/Countersign
( ) Missing
( ) Admit Note
( ) Operation/Procedure Note
( ) Resp Rx Documentation
( ) Disch/Death Note
( ) Post-Anesthetic Note

OPERATION REPORT (SF 516)
( ) Sign/Countersign
( ) Missing
( ) Incomplete

DOCTOR'S ORDERS (DA Form 4256)
( ) Sign/Countersign
( ) Missing
( ) Admit/Disch Order
( ) Date/Time

REMARKS

CONSULTATION REPORT (SF 513)
( ) Sign
( ) Incomplete

TISSUE/PATHOLOGY REPORT (SF 515)
( ) Sign
( ) Incomplete

ANESTHESIA REPORT (SF 517)
( ) Signature of Supervising Physician

TRANSFUSION REPORT (SF 518)
( ) Sign
( ) Incomplete
( ) Date/Amount Given

ELECTROCARDIOGRAPH (SF 520)
( ) Sign
( ) Interpret Tracings
( ) Mount Tracings

DA FORM 4700
( ) Sign
( ) Date

NURSING DOCUMENTATION

___ 1. Progress Note (SF 509)

___ 2. Nursing Data Assess (DA 3888-2)

___ 3. Nursing Data Assess (cont) (DA 3888-3)

___ 4. Nursing Care Plan (DA 3888-4)

___ 5. Nursing Discharge Summary (DA 3888-5)

CIRCLE IF INCOMPLETE

CHECK IF SIGNATURE REQUIRED

FAMC FORM 1548, 1 Sep 84
(Replaces Edition of Dec 78, which is obso

Clinical Nursing Records Study Final Report

Blanchfield Army Community Hospital

Fort Campbell, Kentucky

Major Marybeth Johnson, AN

CLINICAL NURSING RECORDS STUDY

FINAL REPORT

BLANCHFIELD ARMY COMMUNITY HOSPITAL

I. INTRODUCTION

Florence A. Blanchfield Army Community Hospital located on the western Tennessee/Kentucky border, serves a catchment area of 26 counties in Western Kentucky, and all of Tennessee which includes 21,000 active duty service members, 98,000 family members of active duty, 71,500 retired from active duty service members and their family members. Services provided by this MTF include Internal Medicine, General Surgery, Orthopedics, Obstetrics and Gynecology, Neurology, Psychiatry, and Social Services. Other support services include Occupational Therapy, Physical Therapy, Preventive Medicine and Nutrition Care. Additionally, a portion of the Dental Activity is physically located in the facility.

During the implementation phase of the Clinical Nursing Records Study (CNRS), there were 58 ANC Officers, 121 Enlisted Nursing Personnel, 44 Civilian registered nurses, 39 Licensed Professional Nurses (LPN), 25 Nursing Assistants (NA) and 22 clerks in the Department of Nursing. There were 101 Physicians and 26 Physician Assistants on the medical staff during this period.

Prior to training and implementation of the CNRS, the hospital became involved in the Ambulatory Care Data Base Study (ACDB) which involved all clinic personnel. The increased documentation required by the ACDB study aggravated some physicians and could have caused them to be less receptive to additional changes. Some members of the physician staff were very vocal, others openly recalcitrant. Matters were further complicated by the absence of a full time DCCS, therefore there was less pressure to comply placed on physicians .

Accreditation inspection by the Joint Commission of the Accreditation of Hospitals, and the annual IG inspection were scheduled for June 1986, shortly after the official end of the test phase.

II. Implementation:

A. The Hospital Commander and the Chief, Department of Nursing were already aware of the proposed study and had agreed to participate in the test phase, prior to the appointment of this POC. Full support by the Command was evident throughout the study.

B. Logistics:

Receipt, storage and distribution of forms was coordinated through the forms control manager. All forms were sent directly to the forms control manager who coordinated receipt and storage of all forms. The NCOIC of each nursing patient care unit was responsible for ordering sufficient

quantities of forms in the usual manner, on a specific date in December 1985, in time for the selected changeover date. The unit NCOICs were also responsible for obtaining chart dividers from the POC and inserting them into the inpatient records in preparation for implementation. Once the changeover to the test forms occurred, previous editions of the forms were either stored or destroyed. The only glitch in the forms acquisition and distribution process appeared to be the frequent discovery of SF 509 Progress which read "Doctors Progress Notes". The persistent reappearance of this circa 1970's edition of the SF 509 proved to be inconvenient and fueled the physicians complaints that nurses were writing on "their" notes. Therefore a concentrated effort was made to seek and destroy all outdated forms.

C. Training:

Training for the Clinical Nursing Records Study consisted of the following:

a. Selection of additional trainers;

1) Type of position. Head nurses and wardmasters were selected to be resource personnel for their own units. All head nurses and wardmasters were scheduled to attend the first class session. Six (6) nurses in the 66J internship program were selected to help conduct the classes as part of the didactic component of their program. They were chosen because of their availability for training, interest in the program, and wide range exposure to the various hospital units during their rotation, which afforded them high contact with other Department of Nursing Personnel, high visibility, and youthful enthusiasm!

b. Strategies:

1) Marketing of the study was a number one strategy for implementation of the program. As all learners were adults, it was recognized that the learning principles must be appropriate to their level and needs. The study was "sold" on usefulness, i.e., creative use of nursing orders was promoted as a way to decrease time necessary for documentation while increasing the quality and accuracy of this task.

2) As soon as the study information was available, an information paper was given to key personnel, to include the Chief Nurse, Assistant Chief Nurse, and supervisors. The information paper was later given to all clinically oriented personnel (including physicians, Occupational Therapists, Physical Therapists, Dietitians, etc.), and was published in the Department of Nursing Newsletter.

3) Video tapes were not available for use during implementation. An exportable packet of written information was prepared for those unable to attend the class (see DF dated 3 Dec 1985). Class announcements were made via disposition form (see DF dated 3 December 1985).

4) Classes were presented with formal content in an informal workshop atmosphere. As stated. one (1) class was given for the future resource personnel. head nurses, and wardmasters, a few days prior to the

hospital-wide classes. Hospital-wide classes were held sixteen (16} times at varying hours and weekdays, in two-hour sessions each. All classes were taught by two (2) persons on the team-teaching concept. As with other endeavors, NESDS planned, announced, and coordinated all sessions.

5) Physicians were oriented to the test forms in separate sessions. Initially. by prior agreement with the acting DCCS, physicians would receive their orientation at their regular weekly professional development class. However, when only one (1) physician appeared for the session, the POC set up departmemtal meetings at the convenience of the physicians.

c. Miscellaneous:

1) Follow-up information concerning questions that arose during the classes but were unanswered during the class session, was sent via Disposition Form (DF) along with implementation information (see DF dated 11 December 1985). Highlights were also addressed and added to the exportable packets.

2) Use of exportable packets proved useful during the 86th Evacuation Hospital/MEDDAC merger test project. Training for the 5010th Reserve unit backfill personnel was initiated before their arrival at BACH.

D. Implementation of Forms:

1) Implementation of the use of test forms began on 1 January 1986. Inpatient records of all patients admitted after 0001 hours on this date contained test forms. Test forms were also used on for patients who were admitted before this date but remained in the hospital long enough to require the placement of additional forms in their records. While this caused some slight confusion, the number of patients who fell into this category was not large and the length of time these charts were in use was relatively short, therefore the inconvenience was minor.

2) Problems encountered:

a. Overprints: From the very beginning. it was apparent that overprinting of the 3888 would be a problem. The weight of the paper and the bifold design made it too wide to fit in a standard printer when opened, and too thick when closed, to make use of a word processor computer possible for overprinting. None of the printing machines available in this medical treatment facility, nor in the local community had the capability of overprinting a form of this design. When attempts to use a printer/computer to overprint forms led to the destruction of the print head, overprinting from a central location was abandoned. This added to the frustration of the nursing staff who were accustomed to the use of pre-printed nursing care plans for standing orders. Resorting to writing each nursing order and doctor's order on the therapeutic documentation care plan was time consuming and very unpalatable. While some units utilized rubber stamps to imprint individual nursing/doctor orders, the inability to easily overprint the forms remained a hot issue.

b. Inability to use a yellow highlighter to indicate discontinued orders was cited as a problem early in the study and continued to be a problem throughout the test period. When discontinued orders are not highlighted,

current orders are easily missed when buried among discontinued orders. Possible solutions included: a) leaving space between each order on the TDCP; b) drawing heavy or colored lines between each order to more easily separate expired and current orders; c) rescinding the "no highlighter" rule and allowing the use of transparent light blue highlighter which does not photocopy and therefore would not obliterate the original order; d) redesigning the form to include only 7 days documentation (orders would then be recopied every 7 days, deleting the discontinued orders, however, the time required to recopy orders aggravates another problem).

The preferred solution would be to allow the use of transparent blue highlighter to identify expired orders, since it best identifies expired orders without obliterating them even when photocopied, and does not take an inordinate amount of time.

c. The continued use of outdated Doctors Progress Notes and Doctors Order forms was a problem during early phases of the study. This occurred when certain physicians resurrected private stocks of these forms because they preferred them. Continued efforts to remove previous editions of these forms and frequent reminders to the physicians that these forms were not to be used (accompanied by explanations of WHY they were not to be used) eventually solved this problem.

d. The volume of test forms used far exceeded the anticipated use. This became obvious soon after the implementation of the test forms. Since the anticipated use was based on the number of standard forms used previously, the increased use was attributed to the creativity of the nurses who found innovative ways to use the TDCP's to document care more easily and accurately. As nurses became more familiar with the possibilities afforded them by the correct use of the TDCP, more nursing orders were written, and more forms were required. Another positive outcome of the creativity was a very positive comment from the nurse inspector on the JCAH accreditation team, who complimented the very complete documentation of care in inpatient records at BACH. The essence of her comment was that in 300 hospitals surveyed, she had not seen better documentation of the the plan, execution and evaluation of nursing care.

e. Availability of forms: Forms DA 4256-2 (Doctors Orders Non-medication) and DA 4678 (Therapeutic Documentation Care Plan-Medication) were not available in the correct color at the beginning of the test phase. This contributed to the dissatisfaction and confusion of some personnel, associated with the use of the forms. Once forms in the appropriate color were received and distributed for use, comments from personnel indicated that some of the initial confusion would have been lessened by using the correct forms. Nursing personnel generally thought that forms implementation at future sites should not begin until all forms were available in the correct colors.

f. Staff resistance to change: In general, most of the nursing staff supported use of the test forms. Some dissatisfaction and annoyance with the forms was expected and did become evident. Nursing personnel missed the ability to have standing orders overprinted on the DA 4677 and DA 4678. Some physicians were annoyed that nurses were now writing on "their" notes. Physicians initially complained that separating medications and non-medications

required a re-organization of their thinking processes and they didn't like flipping back and forth from med to non-med pages. The fact that the medication and non-medication orders were both initially the same color (white}, further complicated the issue since it was not immediately obvious which of the two similar forms was for medications and which was intended for non-medications. It was necessary to look at the form title or number in order to identify the correct use of the form.

g. Unusual occurrences:

There was only one unusual occurrence during the test phase which could have been related to the use of the test forms. On 6 February 1986, an incident involving a medication being missed occurred. Inability to use a highlighter to indicate expired meds led to a camouflage of the current medication order. It was difficult to determine which orders were still current on a page on which there were many expired orders. While this incident was not due to a change in the format of the form, it was related to a change in policy which occurred as part of the test.

III. Evaluation:

A. Information concerning how the staff felt about making changes to the forms was collected in several ways:

1. Head Nurses were asked to keep a sample of each form available near the nurses station, on which they or members of their staff were asked to make comments or suggestions for change.

2. Users of the forms were asked to complete a questionnaire at the completion of the test period. Responses were collated and discussed when the POC's of the four test sites met at the end of the test phase.

3. Users of the forms were also encouraged to volunteer suggestions or voice complaints through their head nurse, supervisor, or directly to the POC at any time during or after the test period.

IV. Recommendations:

a. Form design changes: Form design changes were discussed in detail at a meeting of the POC's and submitted for inclusion in the final report. The most notable suggestion for change involved the DA 4677 and DA 4678 (Therapeutic Documentation Care Plan) which were tested in a bifold design. Since this made the forms difficult to overprint, the desired format should be one that facilitates overprinting, even if it is necessary to revert to a single page design. Heavy weight paper, such as that used in the test forms, was considered desirable since it was more durable.

b. Implementation suggestions:

1. Prepare a videotaped instruction session that would then be available to all staff members to provide consistent instruction. This medium

would not only be useful for first time orientation to the forms, but would also be useful for periodic reviews for staff.

2. Staff members who could not finish the programmed text during the time allotted in class, were allowed to finish it later and return to NESDS with the completed text. It was later felt that class sessions should be extended in order that all staff members could complete the text during the class period in the event that there were questions unanswered by the programmed text.

3. Format of learning should include more examples with patient diagnosis, sample orders to transcribe, scenarios to work with, etc.

4. Never implement the use of the forms until all forms are available in proper colors, amounts, etc. This could reduce some of the inevitable confusion that results when anything new is implemented.

5. Order more TD's and Nursing Care Plans than you think you need. This MTF used approximately three times the number of TD.s than had been used during a previous like time period. For a hospital with a census of 150, 4000-5000 Nursing Care Plans and 5000 Therapeutic Documentation Care Plan Non-Medication were used per month.

6. Prepare overprints several months in advance. Even though this process was begun early, it required much more time than the head nurses anticipated. The fact that some forms could not be overprinted, added to the frustration and caused some dissatisfaction.

7. Realize that the time required to properly oversee the introduction of new forms is substantial. While implementation went well, the availability of someone to be on the patient care units more initially, would have been ideal.

HSXD-NS
3 December 1985

DISPOSITION FORM

S: 1 Nov 85

For use of this form, see AR 340-15; the proponent agency is TAGO

REFERENCE OR OFFICE SYMBOL	SUBJECT
HSXD-NS	Clinical Records Training

TO Supervisors, HNs, NCOICs FROM C, NETS DATE 18 Oct 85 CMT 1

CPT Bice-Stephens/mlb/8311

1. Implementation of the new inpatient record forms is scheduled in December 1985. Prior to implementation, all nursing personnel will be scheduled to attend a mandatory 2-hour training class.

2. Head nurses (or their representatives), and unit NCOICs should attend a 2-hour training class on 14 November at 0900 in Classroom #1. This will ensure resource persons are trained for each area. Volunteers from this group are also requested to help teach at one of the sixteen classes for the Department of Nursing personnel.

3. Regular classes will be given as listed below. Please ensure that all unit nursing personnel are scheduled for attendance at one 2-hour session. Ward clerks, nursing pool personnel, volunteers, or other persons who will be utilizing inpatient records also must attend.

4. Please send a list of preferred times for attendance for all unit personnel to NETS, NLT 1 November 1985. Class slots will be filled on a first-come, first-serve basis.

5. Available classes are:

Date	Time	Location
18 Nov 85	0730-0930	Classroom #2 (1AB56)
18 Nov 85	1000-1200	Classroom #2 (1AB56)
18 Nov 85	1230-1430	Classroom #2 (1AB56)
18 Nov 85	1500-1700	Classroom #2 (1AB56)
19 Nov 85	0730-0930	Classroom #2 (1AB56)
19 Nov 85	1000-1200	Classroom #2 (1AB56)
19 Nov 85	1230-1430	Classroom #2 (1AB56)
19 Nov 85	1500-1700	Classroom #2 (1AB56)
20 Nov 85	0730-0930	Classroom #2 (1AB56)
20 Nov 85	1000-1200	Classroom #2 (1AB56)
20 Nov 85	1230-1430	Classroom #2 (1AB56)
20 Nov 85	1500-1700	Classroom #2 (1AB56)
25 Nov 85	0730-0930	Classroom #1 (00A08)
25 Nov 85	1000-1200	Classroom #1 (00A08)
25 Nov 85	1230-1430	Classroom #1 (00A08)
25 Nov 85	1500-1700	Classroom #1 (00A08)

6. Volunteers who can assist NETS with one or more of the training classes should contact CPT Bice-Stephens or SFC Brister at NETS, 8311.

WYNONA M. BICE-STEPHENS
CPT, AN
Chief, Nursing Education
and Training Service

DISPOSITION FORM

For use of this form, see AR 340-15; the proponent agency is TAGO

REFERENCE OR OFFICE SYMBOL	SUBJECT
HSXD-NS	Questions and Answers from the Clinical Nursing Records Study Classes

TO: All Section Supervisors and Head Nurses

FROM: C, NETS

DATE: 11 Dec 85

CMT 1

CPT Bice-Stephens/mlb/8311

1. The following are answers to questions brought up in the Clinical Nursing Records Classes given in November 1985, in the Department of Nursing personnel.

a. How will the current audit tool be used during the records study period?

The current audit tool will be revised to not conflict with the criteria presented in the "Forms Guidelines." As stated in the Forms Guidelines, page 38, problem-oriented notes or narrative notes may be used. The nursing process should be evident in the notes.

b. Can 0700-1500, 1500-2300, [illegible] times be used to specify times actions are to be done?

Yes. For orders which are pervasive throughout the shift and are not time-related, inclusive times may be used, e.g., 07-15, 15-23, 23-07. (See page 24, "Forms Guidelines.")

c. Who initials the Patient Discharge Form?

The writer's initials (i.e., the RN) are recorded in all blocks related to patient understanding of discharge instructions. (See page 43, "Forms Guidelines.")

d. Why is there a Doctor's Discharge Summary and a Nursing Discharge Summary?

For the period of the study, both summaries will be used. MAJ Mary Beth Johnson is aware of the redundancy of forms.

e. When will the study be implemented?

The study will begin on 1 January 1986. The phase-in period is January 1986, followed by a 3-month test (implementation) period, February-April 1986.

f. Why doesn't the patient sign the Patient Discharge Summary Form?

The Forms Guidelines, page 43, states that the writer's initials and signature will be on the Patient's Discharge Form. MAJ Mary Beth Johnson will note this as part of the evaluation of the test forms.

g. If there is one RN in L&D or RR who has transcribed some orders and the patient is transferred, what happens about these orders being verified by another RN?

These orders do not get verified by another RN in this situation (which is what we have now). L&D and pre-op orders are discontinued once the patient is on Postpartum or the wards.

h. Can nursing orders and physician's orders be placed on separate green and white sheets?

This is up to the nursing units as to how they want to place the orders, either on the same sheet or on a separate sheet.

i. Do two (2) RNs have to verify all orders or just medication orders?

Per MAJ Johnson, all orders must have RN verification, whether an RN transcribed the orders or not.

2. Attached to this DF is an errata sheet from MAJ Johnson. It gives corrections and changes to the Forms guidelines and programmed instruction manual. Items of change are underlined for your information. Those preceded by "***" are major charting policy corrections.

3. POC for questions and comments regarding the study is the Nurse Methods Analyst, MAJ Mary Beth Johnson, at 8175.

(signed)
WYNONA M. BICE-STEPHENS
CPT, AN
Chief, Nursing Education
and Training Service

Errata Sheet

CLINICAL NURSING RECORDS STUDY--FORM GUIDELINES

Title page: "1 August 1985"

page 5, Figure Number 29: "... for DA form 4678-1 (TEST)"

***page 17, para 14.b., final line: "... or initial of the individual carrying out the order indicates ..."

page 19, first line: "... been completed and requires ..."

page 36, figure 29, title: "... for DA form 4678-1 (TEST) ..."

***page 38, para 38.b.: "... for quality assurance. If there are no specific nursing care plan problems to be reflected in the progress notes, a note is to be preceeded with the words 'Nursing Entry' or 'Nursing Note'."

page 40, para 39.c.: hypenate the word "critical"

page 42, para (1), second line: "... will be made until it ..."

page 43, para (5), third line: "... he asked what he was to do ..."

page 43, para 43.b., second line: "... of instructions."

CLINICAL NURSING RECORDS STUDY: A PROGRAMMED INSTRUCTION

NOTE: Some manuals may be missing page 47-62, and/or have duplicated pages 63-78.

page 12, Block e., sixth line: following the comma, add an additional blank line, i.e., _____ .

page 32, Block 28., third line: "... The individual carrying out the order as having ..."

page 32, Block 29., first line: "The individual carrying out the order signs off ..."

page 32, answer block immediately following Block 29: "individual carrying out the order; no transcriptions" (NOTE: place sufficient blank spaces in the preceeding response to correspond with the number of words in the answer.)

page 39, Block 38., second paragraph: "Preparation:"

page 53, Block 60., response blanks: Eliminate one blank to correspond to the correct number of words in the given answer.

page 60, top block, response blanks: Add one blank to correspond to the correct number of words in the given answer.

DISPOSITION FORM

For use of this form; see AR 340-15; the proponent agency is TAGO.

REFERENCE OR OFFICE SYMBOL	SUBJECT
HSXD-NS	Clinical Records Training Exportable Packet Guidelines

TO DON Personnel Receiving Exportable Packets

FROM C, NETS

DATE 3 Dec 1985

CMT 1:

1. Blanchfield Army Community Hospital has been chosen to be a test site for the Clinical Nursing Records Study. Our facility is one of four selected as test sites. The phase-in period will be January 1986, followed by a 3-month test (implementation) period, February-April 1986. During this time, monitoring will include quality assurance audits, evaluation of unusual occurrences, and staff satisfaction. An 8-month evaluation phase will conclude the study. Our facility will have the option to continue to use the new forms if desired.

2. Since this is a study, all Department of Nursing personnel must receive training in the use of the test forms. Attached are the following:

a. Information paper - general study

b. Information paper - highlights of new forms

c. Clinical Nursing Records Study - Form Guidelines

d. Clinical Nursing Records Study - A Programmed Instruction

e. One copy of each test form (8 total)

3. Suggested training outline:

a. Read both Information papers
b. Read Form Guidelines and review forms
c. Complete Programmed Instruction

4. NETS must have evidence that persons have completed this training, since this is required as part of the study. The Programmed Instruction must be completed and returned to NETS NLT 16 December 1985.

5. POC for the records training is NETS, CPT Bice-Stephens and CPT Spittler, x8311. POC for the implementation and evaluation of the test forms is MAJ Johnson, x8175. Any suggestions regarding changes to the forms should be directed to MAJ Johnson.

Wynona Bice-Stephens
CPT, AN
Chief, Nursing Education and Training

DA FORM AUG 80 2496

PREVIOUS EDITIONS WILL BE USED

DD 1984 0 - 4 --

HIGHLIGHTS OF THE CLINICAL NURSING RECORDS TEST FORMS

HIGHLIGHTS:

1. Nursing history and assessment will be completed within 24 hours of admission. If completed on admission, this will take the place of an admission note.

2. Nursing notes will be written on SF 509 Progress Notes. The SF 510 will not be used. There will be integrated progress notes. SOAP charting will continue, but do have option of narrative notes. Indicate nursing care plan number. Ineffective or omitted actions and medications need a note.

3. Currently approved overprints may be used only if information is not duplicated. MAJ Johnson is working on this with the head nurses.

4. DA Form 3888-2: Personal articles section added. Nursing history may be obtained by any nursing personnel. Categories of assessment printed on bottom of form. DA Form 3888-3 may be used for additional space. Assessment must be by RNs.

5. Nursing Care Plans: Guide for nursing diagnoses listed on bottom of DA Form 3888-4. Must reassess q 24 hours and document on Care Plan or have N.O. on DA Form 4677-1 (green sheet) to "Reassess patient's status and NCP on day shift qd."

6. Doctor's Orders: There will be a separate order sheet for medications and for non-medications. There will also be chart dividers for meds/non-meds. There is a column for single action orders; the individual carrying out the order will sign off here once completed and will not have to transcribe the order if completed on that tour of duty. Pharmacy receives the pink copy of all orders. Routine and delayed orders must be transcribed.

7. No highlighters will be used for discontinued orders.

8. Therapeutic Non-medication: Can be used as a flowsheet at the bedside. Can write q 1-2 hour actions by using slash marks in the blocks (see examples in Forms Guidelines). PRN orders must have reason for order stated. Results for responses may be coded onto this form, eliminating the need for a nursing note. Response codes include: initials only, and initials with either "+" satisfactory; or "0"' unsatisfactory/not observed/omitted.

9. Therapeutic Medication: PRN med orders need a reason for med indicated. Patient response codes include: initials only, and initials with either "E" effective; "I" ineffective; or "0" not given. Ineffective and meds not given require a nursing note.

10. Transcribing Med Orders: An RN must check all med orders that are transcribed. Another RN must check the orders if an RN originally transcribed orders, meaning an RN must check all transcribed med orders no matter who originally transcribed them.

11. Nursing Discharge Summary: 3 copies, carbonless; 1 copy to patient, 1 to inpatient chart, and 1 to outpatient chart. Nurse initials next to "Patient/S.O. verbalizes understanding...." Patient's status at discharge noted at bottom. Indicate on SF 509 if all problems resolved or if any remain; and indicate plan for remaining problems. On SF 509 state "See DA Form 3888-5 (TEST)''.

DS/NETS/8311

Clinical Nursing Records Study Final Report

Moncrief Army Community Hospital

Fort Jackson, South Carolina

Major Patricia Prather, AN

I. INTRODUCTION.

Moncrief Army Community Hospital (MACH) is located at Fort Jackson, South Carolina, which is home to two Basic Training Brigades and one Advanced Individual Training Brigade. The hospital provides primary care to active duty personnel, active duty dependents, and retirees in the surrounding communities. Moncrief has a staff which includes physicians, RN's, LPN's, and nursing assistants. Clinical services provided include internal medicine, oncology, dermatology, allergy, ophthalmology, otolaryngology, general surgery, urology, obstetrics/gynecology, psychiatry, pediatrics, orthopedics, podiatry, and oral surgery. Operating beds are divided among a 14-bed medical-surgical intensive care unit, labor and delivery suite with 14 maternity beds, 15-bassinet newborn nursery, 2 surgical wards, 1 medical ward, minor medical/pediatrics ward, and a psychiatric ward.

During the study period the staff remained relatively stable, with the notable exception of the inpatient nursing supervisor, and the Nursing Education and Training Services (NETS) personnel. Moncrief was simultaneously involved in the Ambulatory Care Data Base Study which caused some physicians to complain that the two studies caused additional work for them. The Commander's support of both projects was well known and facilitated the cooperation received from staff members.

The appointment of the site project officer as Risk Manager for Moncrief coincided with the training and implementation phase of the study. Establishing a viable risk management program consumed a great deal of time and impacted on the time available to the project. As a bonus, though, it allowed the review of all unusual occurrences and added a chance for immediate notification of any quality assurance issues raised by the study.

II. IMPLEMENTATION.

A. As project officer I briefed the Commander, Deputy Commander for Administration, Deputy Commander for Clinical Services, and the Chief, Department of Nursing prior to the Commander's final approval of Moncrief as a proposed test site. The briefing included a history of the need for revised forms, the methodology involved in producing the final proposed form changes, the time frame of the study, and the commitment required of hospital staff to successfully implement the new forms. Very few objections were raised by the group, but concern was expressed about the separation of Doctor's Orders into medication and nonmedication orders. These concerns were expected to cause some difficulties with physician compliance, however the quality assurance measures which could be achieved seemed to outweigh the objections. Consolidation of all clinical notes into an integrated progress note was anticipated as being helpful in promoting interdisciplinary communication.

The Commander thought the appointment of a physician as a project assistant might improve physician acceptance. While the idea seemed to have merit, the individual eventually appointed had very little impact on the project. His clinical responsibilities allowed little time for his participation in planning meetings, and he showed little interest in the project. As a result, I rarely sought his assistance, finding it more advantageous to contact individuals personally who had questions regarding the project.

Throughout the prolonged preparation phase, the training phase, and during the actual study, the Commander and his staff remained faithful advocates of the project. Their support and the interest of the Chief Nurse and his staff enhanced the study and made my job much easier.

B. Logistics

The Forms Manager for MACH was informed of the Clinical Nursing Records Study from the beginning and was continually briefed on the status of the project as it progressed. She arranged for the receipt and storage of the new forms when they were received. Her staff was responsible for the distribution of the forms prior to implementation and for keeping the project officer informed if problems occurred. The chart dividers were received, counted, and distributed by the project officer. Soldiers assigned to the Medical Holding Company were tasked to insert the pull tabs in the chart dividers prior to their distribution to the wards. Sufficient chart dividers were received to insert in all charts, and the remainder were shipped to the project officer at Fort Campbell who experienced a shortfall.

The test forms were actually stored with other publications because no alternative space could be identified in the warehouse, and the publications area was staffed by a single individual, making storage in the hospital inefficient. This did not present any problems until the forms were depleted and one order was filled with the old forms. Unit staff immediately notified the project officer and the situation was corrected by redistributing forms in areas that were overstocked. Areas with minimal usage, outpatient clinics, exceeded their requirements and were found to be storing large quantities of the test forms.

C. Training.

1. The Chief, Department of Nursing, in consultation with the project officer, selected the Chief and NCOIC, Nursing Education and Training Service, as additional trainers. Since these two individuals were accustomed to teaching, were responsible for orientation of new personnel, and did not have patient care responsibilities, they were determined to be the best candidates. They were known by the nursing staff and were active participants in morning report where the nursing executive group met each day for information sharing and problem-solving. The Chief, NETS, was an Evening/Night Supervisor at MACH before being assigned to the NETS position so she was particularly knowledgeable about the inpatient services.

2. The division of training responsibilities was decided before the initial orientation at Fort Sam Houston. NETS would be responsible for training nursing personnel while the project officer would train all others. All training was done in person for better communication with the participants. The prepared information papers were distributed to all staff members prior to the training sessions. All training made extensive use of the prepared transparencies. Packets of the new forms were distributed at the training session and collected for reuse at the end of each class.

Nursing staff were trained using the Chain of Command. The executive group was trained first, followed by head nurses; scheduled classes were [illegible]

for all other nursing staff members. The programmed instruction booklets were distributed prior to class, but most of the staff had not completed them by class time so they were used during the two-hour training session.

The Physical Therapy, Occupational Therapy, and Nutrition Care staff were given a separate class during their weekly inservice training session. This class lasted an hour and covered all the new forms and use of the integrated progress notes. No difficulties were anticipated with this group, but they needed to know where to locate information in the patient's record. They did not express any anxieties about the change and were relieved that no additional work would be required of them. (This group was feeling pressed by the Ambulatory Care Data Base Study).

All other staff members were requested to attend one of five scheduled classes given for physicians, inpatient records staff, administrative staff, and other ancillary staff members. The first of these five sessions was held during the regularly scheduled Professional Staff Conference. The Commander and his staff attended one of these sessions since they did not want a special class.

In addition to the classes which were held (all during November 1985), the project officer spoke to the Department of Nursing Staff meeting and the Head Nurses meeting. All three trainers were available for consultation throughout the project.

Staff changes in NETS occurred in January 1986 but this did not create any major difficulties. The new acting Chief, NETS, and her NCOIC were trained by the outgoing Chief, NETS, and the project officer remained constant during the entire implementation and testing period. The project officer was reassigned to Germany in June 1986, and responsibility for continuation was given to the Chief, NETS.

3. DF's were sent to all nursing personnel with the class schedules (Encl 1). A similar DF was sent by name to each physician and all department and service chiefs announcing the classes to be given by the project officer. It was attached to the information letters, but has been lost. Classes were given by the project officer on the following dates and times:

22 Nov 85 - 1200 hrs (Prof. Staff Conf.) 25 Nov 85 - 1000 and 1400 hrs
27 Nov 85 - 0900 hrs
29 Nov 85 - 0830 hrs

In addition to the DF's, staff members were reminded of the classes at virtually every meeting held during November 1985. Between the Chief, NETS, and the project officer we served on all major hospital and Department of Nursing Committees. The project officer also volunteered to schedule any special training sessions desired by any of the activity chiefs. The only group that responded to this offer was the PT, OT, NCD group mentioned previously.

D. Implementation of Forms

The project officer coordinated with the forms manager for initial orders for new forms to be processed starting on 25 Nov 85. Head nurses (HNs),

wardmasters (WMs). and clinic NCOIC's were informed through their chain of command when to submit forms requests. The project officer personally distributed all chart dividers on 25 Nov, using that time to inform ward clerks and head nurses of the procedure to be followed on 1 Dec when the new forms were to begin. A DF (Encl 2) had been sent on 22 Nov to all HNs and WMs outlining the procedure to be followed during implementation, problems encountered already, plus additional information about the study.

On 1 December (which was a Sunday) the project officer visited all wards and the emergency room (ER) to check on implementation. Three patients had been admitted that day, all to the minimal care ward. The first problem surfaced immediately: the ER did not have any overprinted standing orders on the new forms (for the minimal care ward). The supervisor had procured the overprints from the ward, and the project officer left instructions for the WM to order sufficient overprints the next day.

The ward was not experiencing any real problems with the forms. Orders had not all been verified, and the traditional admission note was used rather than the abbreviated note with the admission history and assessment. The biggest problems actually surfaced long before 1 December.

When the forms were received, it was discovered that the color coding for Medication and Nonmedication Doctors Orders, as well as the Medication and Nonmedication Therapeutic Documentation Care Plans (TDs) was in error. Additionally the slash mark which was to have been over the "0" (to indicate that a medication had not been administered) on the codes for the Medication Therapeutic Documentation Care Plan had been deleted. A decision was made to go ahead with the test dates, anticipating the arrival of corrected forms in the middle of the study. The corrected forms actually arrived at the end of the study and this error may have added to the difficulties experienced by some physicians in separating their orders. The nursing staff were all informed of the errors immediately and did not seem to have much difficulty adjusting. Some wards used ambulatory patients to add the slash mark by hand; others simply added it themselves when coding a medication that was not administered.

The biggest problem for nursing staff was the inability to overprint the TDs and the Doctors Orders. Reproduction equipment at MACH, Fort Jackson, and Eisenhower Army Medical Center, (Fort Gordon, GA) were all unable to overprint the two types of forms. After many hours on the phone, messages to and from the principal investigator, and much trial and error, the only machine capable of overprinting the forms was found to be authorized only at Government Printing Offices or by using a word processor which required manual feeding by a staff member. Neither of these options was considered practical by the MACH command group, so permission was obtained from the principal investigator to copy the front page of the Doctors Orders, type on that single sheet any standing orders, then reproduce those orders as single sheets. Pharmacy was given copies of all standing orders for their review purposes. The overprinting of TDs was handled differently. For short orders, rubber stamps or printed addressograph plates were used. Some wards used the word processor in the Chief Nurse's office, while others copied standing orders by hand onto the TDs during slack times.

The problems created by the overprinting difficulties cannot be over-emphasized. Nursing staff and physicians were upset, angry, and eventually

creative in their adaptations. The use of DA 4700's to overprint standing orders had been the general practice prior to the study, and was caused by the inability to overprint the "old" Doctors Orders. Forms personnel cited the three part form as the difficulty. The TDs were not reproducible due to the heavier weight, and the folded form.

Throughout the overprinting crisis, staff were reminded to consider the issue as a possible trade off: sturdier, more flexible forms for ones that could be overprinted. The problem did cause a lot of extra work for everyone involved and may have created a less than favorable attitude to initiate a study of this magnitude.

Another issue was raised by the Chief of Inpatient Records. She pointed out that the Doctors Orders were not a standard size when the perforated bottom section was removed, and this made the final patient record look a bit sloppy. She also noted that the lines on the Doctors Orders were not consonant with standard typewriter line spaces, so overprints using word processors looked uneven. The bulk added to the record by the heavier TD sheets also created extra weight for records storage.

Other questions raised during the study included:

(1) The Intensive Care Unit tried to adapt their flow sheet, Cardiac Rehabilitation protocol, and Tylenol Overdose protocol to the new TDs. After a great deal of work, the new TD was unrecognizable. They were allowed to continue using these three overprints.

(2) Physicians wanted pull tabs on both medication and nonmedication chart dividers, as well as the "stat order" tab.

(3) The perforations on the doctors orders were often uneven, creating an uneven edge when separated.

(4) Physicians complained that the additional column (to note completion of single action orders) gave them less space to write orders.

(5) The guidelines and programmed texts were printed incorrectly. Corrected sheets were received during the phase in, Dec 85, and were distributed at that time to all areas (Encl 3).

(6) Staff had difficulty adapting to the new concept of using TDs as primary form for nursing documentation. Head nurses and clinical specialists helped by writing sample nursing orders. The Newborn Nursery was particularly creative in using the new forms.

(7) The principal investigator and a co-investigator visited MACH 11-13 Dec 85. They visited staff on all three shifts which had a very positive impact on the staff. Some wards (particularly Labor and Delivery and ICU) still wanted to transcribe single action orders; the study did not preclude this. Some concern was raised about the effectiveness codes - i.e., does "E" mean a drug was 100% effective? The investigators said if there was any explaining the patient's response. Staff were often forgetting to verify all orders. Nursing notes were frequently not preceded by "NCP#" or "Nursing Entry" as required by the guidelines. Not having any specific guidelines for the required frequency of charting made some staff uncomfortable. Most of

these issues were felt to be part of the learning process and, in fact, many concerns raised initially were alleviated as the staff became more familiar with the guidelines and the forms themselves.

(8) Staff frequently questioned the lack of a space to note patient understanding on the discharge record. Some added a space themselves despite assurance that this had been considered and rejected based on a legal opinion (from JAG, HSC) that it would not be valid.

(9) When recurring orders were continued on the reverse side of the TD, it was feared that they might be missed. The staff was instructed to write in "continued on reverse'' as needed.

(10) The ICU had to change from clipboards maintained at the bedside to a ringed board to hold the new TDs.

(11) One head nurse wanted to know why a discharge note had to be written in addition to the discharge summary. Why wasn't it treated like the admission note?

(12) One ward kept a copy of the guidelines at the nursing station. They had put each page in a document protector and kept the entire document in a three-ring binder with other ward references. Their example was suggested to the other head nurses, many of whom did the same for easy reference.

(13) Many staff members complained about the loss of the yellow highlighter to distinguish discontinued orders. Two unusual occurrences related to the new forms occurred during the four months of the study. The first occurred when an order was missed that was on the reverse of the TD. The "continued on reverse" notation mentioned previously appeared to solve that problem.

The second error occurred on a unit still using medication cards and was felt to be a result of that practice rather then the test forms. A medication order had been discontinued and was correctly noted on the medication TD, but the medication card was not destroyed.

E. Decision to Continue with Form Use.

The decision to continue using the test forms beyond the study period was made after discussions with the nursing staff and the command group. Initially the Commander wanted to continue with the new forms with the exception of the separate order forms. After being assured by the principal investigator that the test forms were a package deal, he agreed to continue with all forms. The consensus was that, despite some problems, the test forms were far superior to that which existed prior to the study.

III. EVALUATION.

a. All participating staff members were sent a DF (Encl 4) requesting input to assist with the evaluation. All nursing units responded as well as three of the physicians. The physicians had each received a DF addressed to them personally and handcarried by the project officer. The poor response was not unusual and most of the physicians had already made their feelings known to the project officer.

b. Generally, the test forms were judged to be better than the old ones. Besides the specific comments listed below in "Recommendations," the majority of nursing staff and physicians wanted to go back to a single Doctors Orders. The separation made nurses look in two places for new orders. Physicians felt it created more work for them, and some continued to write consolidated orders despite repeated attempts to explain the purpose of and correct manner to use the separate order forms.

c. As with any change this study showed that people require time to change. Correct use of the forms continued to improve during the study period, but some nursing documentation suffered. The emphasis on creative, flexible use of the TDs resulted in no documentation in some cases. Since the staff seemed unsure how to use the TDs, but knew they were not expected to write the traditional narrative notes, the result was insufficient nursing documentation. The Chief Nurse assigned Evening/Night Supervisors to assist the project officer in monitoring documentation. He finally issued a DF to all nurses requiring charting frequency based on patient acuity. (Encl 5.)

IV. RECOMMENDATIONS.

a. Form design or guideline changes (compiled from staff evaluations):

(1) DA Form 3888-2 (TEST) Medical Record -- Nursing History and Assessment.

(a) delete block "Typed or Printed Name of RN" - covered by required signature sheet in record.

(b) add date and time block to top of back page.

(2) DA Form 3888-3 (TEST) Medical Record Nursing History and Assessment (continued). NO CHANGES RECOMMENDED.

(3) DA Form 3888-4 (TEST) Medical Record Nursing Care Plan

(a) Print on heavier weight paper.

(b) Add a statement "Care Plan Reviewed with Patient" and block for patient to initial.

(4) DA Form 3888-5 (TEST) Medical Record Nursing Discharge Summary.

(a) Add a block at the top for "Discharge to Duty:" since many patients are military.

(b) Under section "V. Follow up," delete the redundancy in the two appointment sections.

(c) Patient should get second copy or improve the carbon. The third copy is often illegible without very hard pressure being used when writing.

(5) DA Form 4256-1 (TEST) Clinical Record Doctor's Orders for Medications.

(a) Keep the column to note single action orders.

(b) Go back to a single Doctor's Order form.

(6) DA Form 4256-2 (TEST) Clinical Record Doctor's Orders for Non-medications. SAME COMMENTS AS (5), ABOVE.

(7) DA Form 4677-1 (TEST) Clinical Record Therapeutic Documentation Care Plan for Nonmedications.

(a) Cutaway bottom of TD sheet and imprint patient identification on inside sheet so it is visible from both sides.

(b) Add a space on the front sheet to write the year, so it does not have to be written when dating each entry.

(c) This form must be revised to make it easier to overprint. Return to single page but maintain sturdier paper. The front page could be for recurring orders and the back would be divided between PRN orders and single action orders.

(d) Return the use of yellow highlighter to note discontinued orders.

(e) Patient identification should be printed on both sides of the form.

(f) Add "continue on reverse."

(g) Heavier weight sometimes caused addressograph stamp not to print clearly, but extra weight still should be kept.

(8) DA Form 4678-1 (TEST) Clinical Record Therapeutic Documentation Care Plan for Medications. SAME COMMENTS AS #7 ABOVE.

(9) Use of integrated Progress Notes.

(a) The staff was divided on this issue; half wanted it to continue and half wanted to return to Nursing Notes.

(b) The old Nursing Notes were generally kept with other nursing records making it easier to reference the Nursing Care Plan. All wards continued to separate nursing forms from the rest of the patient's chart and found it difficult to note the nursing care problem when charting.

b. If this study were repeated or these forms are implemented Army-wide, I would change the method of training and would wait until correctly printed forms were available. There were so many changes to adjust to that staff needed more time to "practice" with the new forms. A two-hour teaching session going through the programmed instruction should be coupled with two additional hours learning to use the new TDs more effectively. The documentation problems encountered at MACH were largely attributable to the staff's difficulties in writing more concise nursing orders for routine documentation, rather than lengthy narrative notes. Samples could be developed, then allow

the nurses to practice in a guided session.

The printing difficulties and delay in receiving correctly color coded Doctors Orders and TDs may have influenced the evaluation of maintaining the separate Doctors Orders. When individual nurses were asked why they wanted to go back to a single Doctors Orders form, the answer most often given was, "The Doctors won't use them, or use the wrong form." It is difficult at this point to evaluate whether the outcome would have been different if the forms had been correctly color coded from the beginning.

In summary, I think the test forms offered many changes for the better, and with the suggested changes should be implemented for use throughout the Army medical system. At my new duty station, I often wish we had them!

DISPOSITION FORM

For use of this form, see AR 340-15; the proponent agency is TAGO.

REFERENCE OR OFFICE SYMBOL	SUBJECT
HSXL-PN	Mandatory Classes for Nursing Personnel: New Forms

TO All Nursing Personnel FROM C, NETS DATE 13 NOV 85 CMT 1

1. Mandatory classes for all nursing personnel will begin the week of 18 NOV 85. These classes are to reinforce and clarify the information included in the programmed instruction guideline handouts which you have received. Head Nurses and Ward Masters are encouraged to schedule their staff to avoid overloading a single offering.

2. The class schedule will be as follows:

Monday	Tuesday	Wednesday	Monday	Tuesday	
18 NOV	19 Nov	20 Nov	25 Nov	26 Nov	DATE
0730	0730	0730	0730	0730	Start time
1300	1300		1300	1600	Start time
1600	1600				Start time

3. The classes will be held in the NETS Classroom #725.

4. The implementation date for the new forms test is 1 December 85. These are the forms y have all been waiting for-and are long overdue!

Linda Freeman

LINDA FREEMAN
MAJ(P), ANC
Chief, NETS

Encl 1

DA FORM AUG 80 2496 PREVIOUS EDITIONS WILL BE USED ☆ U.S. Government Printing Office: 1983—

DISPOSITION FORM

For use of this form, see AR 340-15; the proponent agency is TAGO.

REFERENCE OR OFFICE SYMBOL	SUBJECT
HSXL-AC	CLINICAL NURSING RECORDS STUDY

THRU: C, DON FROM NMA DATE 22 Nov 85 CMT 1

TO: HN's and WM's MAJ Prather/pfp/2125

1. The Clinical Nursing Records Study is rapidly approaching! Your continued assistance in the changeover process is greatly appreciated and needed.

2. New chart dividers for the physician order forms have been distributed to all wards to be placed in the charts by the evening or night staff on 30 Nov.

3. Be sure to save the old chart dividers should they be required on 1 April.

4. Seven classes have been conducted to date with poor attendance. Knowing the conflicts with SQT testing and details this past week, I appreciate the response we have had. Four more classes will be given next week in NETS and you are reminded that attendance is mandatory for DON personnel, including all ward clerks.

5. On 1 December the forms will be implemented for all new admissions and will continue to be used until further notice.

6. Patients still hospitalized on 15 December who were admitted prior to 1 December will have both types of forms. On 15 December all blank forms (old) will be removed, and the new forms inserted in any such records. TD sheets will have be recopied, but other forms can be left as previously written. Any questions about this process can be addressed to me on 16 December.

7. Forms can be ordered now to allow time next week for the preparation of admission packets prior to 1 December.

8. Standing orders should be typed on the blank Dr. order sheets which have been distributed. Additional copies are available in my office.

9. No solution has been found to overprinting the TD sheets, unless you can use rubber stamps, addressograph plates, or a word processor. The trade-off may be for a more durable and flexible TD sheet. This is not a dead issue and is still being explored.

10. I will be available on 1 December for any questions. MAJ Bell, Principal Investigator, will be here 12-13 December, so if I can't answer your question, we can get it answered then.

11. Hang in there--I'm sure the creative spirit will triumph and obstacles will be overcome.

Patricia F. Prather

PATRICIA F. PRATHER
MAJ, ANC
Nurse Methods Analyst

Encl 2

DA FORM AUG 80 2496 PREVIOUS EDITIONS WILL BE USED ☆ U.S. Government Printing Office: 1983—406

DISPOSITION FORM

For use of this form, see AR 340-15; the proponent agency is TAGO.

REFERENCE OR OFFICE SYMBOL	SUBJECT
HSXL-AC	CHANGES TO CLINICAL NURSING RECORDS STUDY - GUIDELINES

TO ALL NURSING UNITS FROM NMA DATE 4 Dec 85 CMT 1

MAJ Prather/pfp/2125

1. All nursing units are asked to make the following pen and ink changes to the published Form Guidelines for the Clinical Nursing Records Study.

2. The changes are:

a. page 1 - change the date to 1 Aug 1985

b. page 5 - Figure no. 29 should be "DA Form 4678-1"

c. page 17 - Item 14b, change the third sentence to "The time and signature or initia of the individual carrying out the order indicates that the order has been completed and requires no transcription to the DA Form 4677-1 (TEST) or DA Form 4678-1 (TEST).

d. page 36 - Figure 29 should be labeled DA Form 4678-1 (TEST)

e. page 38 - Item 38b, add the following sentence to the end of this item: "If there are no specific nursing care plan problems to be reflected in the Progress Notes, a note i to be preceded with the words 'Nursing Entry' or 'Nursing Note'.

f. page 39 - Item 38f, change the notation from "error in recording" to "error".

3. Any questions about these changes should be addressed to the project officer.

Patricia F. Prather

PATRICIA F. PRATHER
MAJ, ANC
Nurse Methods Analyst

Encl 3

DA FORM AUG 80 2496 PREVIOUS EDITIONS WILL BE USED ☆ U.S. Government Printing Office 1983—4

DISPOSITION FORM

For use of this form, see AR 340-15; the proponent agency is TAGO.

REFERENCE OR OFFICE SYMBOL	SUBJECT
HSXL-AC	Review of Test Forms

TO Staff, Dept of Nsg
Staff, Dept of Surg
Staff, Dept of Medicine
Staff, Dept of Psych

FROM NMA

DATE 8 April 86

CMT 1
MAJ Prather/lmc/2125

1. Test forms were implemented on 1 December for a test period of four months.

2. While the official evaluation period has been completed, the results of the trial usage are just now being sought.

3. Members of the research team from HSC will be here the end of May but have requested your input prior to their official visit.

4. Please send me any comments regarding the test forms, the programmed text, or the forms guideline. I will be taking your comments to HSC on 1-2 May for review with the other test site coordinators.

5. Comments should be addressed to each form (listed below) or booklet and returned to me NLT 25 April:

DA Form 3888-2 (TEST) Medical Record--Nursing History and Assessment
DA Form 3888-3 (TEST) Medical Record--Nursing History and Assessment (Cont'd)
DA Form 3888-4 (TEST) Medical Record--Nursing Care Plan
DA Form 3888-5 (TEST) Medical Record--Nursing Discharge Summary
DA Form 4256-1 (TEST) Clinical Record--Doctor's Orders for Medications
DA Form 4256-2 (TEST) Clinical Record--Doctor's Orders for Nonmedications
DA Form 4677-1 (TEST) Clinical Record--Therapeutic Documentation Care Plan for Nonmedications
DA Form 4678-1 (TEST) Clinical Record--Therapeutic Documentation Care Plan for Medications

Patricia F. Prather

PATRICIA F. PRATHER
MAJ, AN
Nurse Methods Analyst

CF: C, Dept of Nsg
C, Dept of Surg
C, Dept of Med
C, Dept of Psych

Encl 4

DA FORM AUG 80 2496 PREVIOUS EDITIONS WILL BE USED GPO : 1984 O - 455-151

DISPOSITION FORM

For use of this form, see AR 340-15; the proponent agency is TAGO.

REFERENCE OR OFFICE SYMBOL	SUBJECT
HSXL-PN	Nursing Documentation in the Clinical Record

TO All Clinical Head Nurses FROM C, DON DATE 14 Apr 86 CMT 1

NMA

COL Pfaehler/pry/2119

1. During the past several weeks I have reviewed inpatient records from the different nursing units. I am concerned that the nursing process is not being adequately documented in the patient's record. As you are aware the nursing process is a systematic, problem solving thought process which is essential to accomplishing specific, predictable, individual ized care. Listed below are some of my observations as they relate to documentation of the elements that make up the nursing process.

a. Assessment. The documentation of baseline nursing history and assessment on the charts I have reviewed are excellent. The nursing history and assessment are being completed upon admission as required and are IAW the AMEDD Standards of Nursing Practice.

b. Planning. The Nursing Care Plan (NCP), DA Form 3888-4 being completed upon admis sion and nursing problems have been identified. However, for problems identified on the NCP there should be corresponding nursing interventions written as nursing orders on the Therapeutic Documentation Care Plan (TDCP) which reflect the numbers of the identified problems. The "date accomplished" opposite each expected outcome on the NCP must be indicated. Recomme that the RN who completes the Nursing Discharge Summary ensure that the "date accomplished" o the NCP is indicated for each problem identified on the NCP. Those nursing units utilizing a standard NCP must ensure that the NCP is individualized for each patient, i.e., delete proble that do not apply and add additional problems that may not be included in the standard NCP. In the majority of records I have reviewed "discharge considerations" have not been documente on the NCP. Discharge planning should begin at admission with the assessment by the RN. The initial note in the "Discharge Considerations" block should be made by the RN completing the NCP on admission.

c. Implementation. If used appropriately the TDCP should subsume the majority of incidental and routine charting related to the efficacy of nursing interventions and other patien responses. However, most of the records I reviewed revealed inadequate documentation of nursing interventions, eg.

(1) Most of the "recurring actions" on the TDCP were the result of physician orders and not nursing orders.

(2) Problems identified on the NCP were not addressed with a nursing order.

(3) Effectiveness codes (+ or -) were not being utilized, therefore it was difficu to determine whether the nursing intervention and/or observation was satisfactory or not.

(4) Progress Notes in most records revealed very few nursing notes.

d. Evaluation. Evaluation of the effects of nursing actions during and after implementation determines the patient's response and the extent to which goals are achieved. It was difficult to determine the patient's status from the nursing progress notes, i.e., was the patient making progress or not? Were the goals on the NCP accomplished?

Encl 5

DA FORM 2496 AUG 80 PREVIOUS EDITIONS WILL BE USED ★U.S. Government Printing Office 1983—40

HSXL-PN
Nursing Documentation in the Clinical Record

2. I appreciate the hard work and long hours that you and your staff have devoted to providing our patients with quality nursing care. I have reviewed some of the patient survey forms completed by your patients and the overwhelming majority of your patients have been very complimentary of the care they received while a patient on your nursing unit. However, we must ensure that the care provided to our patients is adequately documented in the clinica record. As you know, the MEDDAC will be inspected by the HSC IG team during the week 5 - 9 May. LTC Greenlee, an ANC officer detailed as an IG, will be inspecting the Department of Nursing. The major part of her inspection will be to evaluate the quality of nursing care you and your staff provide to your patients. Since she will be here for only i week, she will reach her conclusions by inspecting such things on your unit as tne:

a. Training of your staff, i.e., your unit orientation and inservice programs, CPR certification, RN/LPN licenses, civilian performance standards, quarterly counseling

b. Ward SOP's as they relate to your specific ward.

c. Your Standards of Care

d. Unit QA Program

e. Documentation of Nursing Process in the clinical record, etc.

3. I want each clinical head nurse to place added emphasis on nursing documentation to ensur that the nursing process is being documented. Until such time as you and MAJ(P) Driggers determine that the nursing documentation on the NCP and TDCP is reflective of the care provided, the following as a minimum must be documented:

Nursing Notes documented on the SF 510 based upon the acuity of the patient.

(1) Once per shift for category 4, 5, & 6

(2) Once per day for category 2 & 3

(3) Once per week for category 1

KARL H. PFAEHLER
COL, AN
Chief, Department of Nursing

Clinical Nursing Records Study Final Report

Bayne-Jones Army Community Hospital

Fort Polk, Louisiana

LTC Sharleen G. Meyers, AN

Introduction

Bayne-Jones Army Community Hospital is a 169 bed hospital supporting the Fort Polk MEDDAC. This MEDDAC serves a population of 13,600 active duty soldiers (primarily assigned to the Fifth Infantry Division), 16,200 dependents, and 10,000 retired personnel and dependents.

The medical staff is comprised of 43 physicians in the following specialty areas - Family Practice, Aviation Medicine, General Surgery, Orthopedics, OB/GYN, Internal Medicine, Pediatrics, Dermatology, Radiology, Psychiatry, and Ophthamology. Additional services are provided by Social Work, Podiatry, Optometry, Physical Therapy, Occupational Therapy, Audiology, Preventive Medicine and Clinical Dietetics.

The largest department in the hospital is the Department of Nursing. Personnel in this department number 93 professionals and 185 allied health professionals.

During the time of this test the ambulatory care data base study was also in progress in the outpatient clinics. Consequently, the physicians were already tasked with additional documentation requirements.

Implementation

The original project officer was not involved in the decision making process to allow the study to be conducted at this site.

The Commander, and the Chief, Department of Nursing apparently made that decision based on information received from and communication with the Commander of Health Services Command, and the Chief, Army Nurse Corps.

Approximately six months before the study was actually started, an information paper (see Appendix A) was distributed to the Commander, the Headquarter's staff, MC, AMSC, MSC officers and Department of Nursing's personnel. The project officer held individual meetings with key officers to discuss actual implementation and to answer questions. The key officers included the Chief of Clinical Support Division, Chief of Pharmacy and the Chief of Patient Administration Division.

Logistics

The logistics of actually receiving, storing, and distributing the test forms were coordinated with the Records Management Officer. She selected one individual to assume sole responsibility for the test forms. Test forms were stored all together in one corner of the Materiel Distribution Service storage area. The person in charge was/is the only person authorized to distribute the forms and is continuing to do so.

The one time distribution of chart dividers was accomplished by the NCOIC of one clinical nursing section. In a MEDDAC of this size that was easily accomplished.

At the time set aside for initial distribution of test forms, NCOICs were directed to turn in unopened packages of the DA forms being replaced by the test forms. The DF dedicated to that subject also covered the dispositon of all remaining loose copies of the non-test forms (see Appendix B). Since training classes were not scheduled for the key personnel who worked in the various out-patient clinics, they did not understand the importance of removing old forms from the system. Consequently, when physicians admitted patients directly from the clinics they frequently utilized the old non-test doctor's order sheets as the old forms had not been purged from the system. That was a significant logistical error that impacted on the smooth implementation of the test forms.

Training

The Chief of NETS was selected as a trainer at the beginning of the project. She was selected because of her position as Chief of NETS. It was felt that the incumbent of that position could manage a Department of Nursing-wide education program. She also had the support of an NCOIC and one secretary.

An ANC officer who was a clinical staff nurse was also selected as a trainer in June 1985. He was selected due to his projected availability as a trainer for personnel working rotating shifts. That would also place a trainer in-house after duty hours to serve as a resource person.

One additional trainer was utilized, in part, due to the logistics of the situation. The NCOIC of NETS actually was utilized as a trainer more frequently than the designated clinical staff nurse. The NCOIC of NETS was readily available when the bulk of the training was scheduled. He also provided documentation orientation for new permanent party and other personnel assigned to the Department of Nursing.

As indicated earlier, the information papers were sent to the Headquarters staff, division and department chiefs, Department of Nursing staff and other involved professional staff in August 1985. In October 1985 the first project officer briefed the key Department of Nursing staff on the progress of the project. She then held individual meetings with the chiefs of Social Services, Clinical Support Division, Patient Administration Division and the Pharmacy. During the November-December 1985 time frame the current project officer again informally met with the chiefs of Social Services, Clinical Support Division, Patient Administration Division and the Pharmacy to discuss final logistical plans for implementation of the new forms.

A formal training schedule was devised to provide formal training for the Department of Nursing staff who were assigned to the in-patient units. The initial session was set up for Chief Nurse's office staff, clinical head nurses and all other ANCs who work week-end/holiday coverage in the Chief Nurse's office. Subsequent sessions were scheduled for specific groups as follows - staff nurses, LPNs/91Cs, nursing assistants, 91As/91Bs/91Fs, and ward clerks. The time allotted for each class was four hours. This included time to complete the Programmed Instruction. It soon became apparent that four hours was a more than sufficient allotment.

The Documentation Study Training Outline was followed and the prepared transparencies were utilized in presenting the material. After the staff in

position at the initiation of the study had been oriented a video tape was prepared to be utilized to train in-coming personnel.

A special training session was held in the Operating Suite to familiarize the operating room and anesthesiology staffs on the specific forms that would be utilized by them . That session was set up at a time consistent with their peculiar tour of duty.

Some Medical Corps department and service chiefs were briefed on an individual basis. When the DCCS held a staff meeting for all MEDDAC physicians, time was set aside for the project officer, and the Chief of NETS, to brief the bulk of the physician staff. One week later the DCCS put out a DF to all physicians highlighting the key points covered in the briefing session.

The training for the Department of Nursing staff began 6 weeks prior to the kick off of the study. The meetings with the physicians were held approximately 10 days before the phase-in started.

Implementation of Forms

The study started on 21 January 1986. One problem encountered before the phase-in period started was related to overprinting standard orders on the Therapeutic Documentation forms. Our solution was to develop rubber stamps to be utilized by each unit for standing orders. There were some problems encountered with actual use of the stamps and getting the stamps lined up with lines and boxes on the forms.

The overprinting of standing doctor's order sheets was addressed prior to phase-in. Our facility's publication section did not have the capability to overprint through all three pages of the DA 4256-1, 4256-2 or 3888-5 forms. In researching this problem it was decided that the above forms would be overprinted by utilizing the word processor printers.

All of the overprinted doctor's orders were placed on a single diskette. In addition, overprints for one 3888-2 form and three 3888-4 forms were included. The remaining two overprints on the diskette were for DA 3888-5 forms. The grand total of 19 individual overprints was to be reproduced utilizing the word processor printer.

The Records Management Officer was involved in all discussions related to overprinting forms. She was unable to provide logistical support in the form of personnel or equipment to actually overprint on the word processor printer.

An initial supply of overprinted forms was produced by a soon to be retired Seargent First Class who in essence was in an excess mode. She had to do her work after normal duty hours or during the lunch hour when the secretarial staff was not utilizing the word processor printers. Availability of the printers became a very real problem as the competition for time on the equipment was intense.

Initially, the overprinted forms were stored in a cabinet in the Chief Nurse's Office. Managment of these forms was subsequently transfered to the one individual in publications who was responsible for storing and controlling all blank study forms.

Eventually, the decision was made to print a single copy overprinted doctors order sheet for standing physician's orders for medications. This single copy would remain in the patient's record. A single physician's order would be written on a standard three part doctor's order sheet to initiate standing medication orders. The pink copy would be sent to pharmacy where a copy of all standing orders was on file. The pharmacy service would then process the appropriate set of orders. Single copy overprinted doctor's order sheets for standing physician's orders for non-medications were also printed.

Since the Publication Section had the capability to print single copy order sheets, and could support requests for same, it eliminated the need to find a word processor printer and personnel resources to overprint the three part forms. This was an important solution to a major logistical problem. Seventeen documents formerly printed on word processor printers were now being reproduced as single copies by the Publications Section printers. The remaining two documents being overprinted on the word processor printer were DA 3888-5 Discharge Summary forms utilized by the Newborn Nursery staff and the Postpartum ward staff. These two forms continue to be overprinted by the units' ward clerks utilizing word processor printers. The access to word processor printers has continued to be an intermittent problem and seems to be minimal at present.

In general, ruffled feathers were smoothed by face to face discussion of problems. This project officer used public relations techniques including listening to complaints, soliciting help/assistance from the irate/offended individuals and offering assistance to brighten the day.

There were no unusual occurrences that could be related to documentation on the test forms. The specific forms were not a causative factor only the individuals inadequate performance at a given point in time.

The problem generated when all non-test doctor's order sheets were not removed from the out-patient clinic areas (see the Logistics section) was resolved when all extraneous forms were successfully purged from the system. This prevented an increase in the incidence of ruffled feathers.

The two major problems related to actual utilization of the test forms were a lack of nursing orders specific to individual patient's current problems and insufficent documentation of patient care/progress on the SF 509. In September, the Chief of NESD was given a project to assist each unit with ways to improve their documentation. She actually worked on some units to get a feel for "applying theory in practice." The end results were included in a three page hand out entitled "How to Make Care Plans Work For You." In addition, an effort was made to standardize intravenous therapy nursing orders. Rubber stamps of nursing orders were made for each unit and inservice classes were presented by the Infection Control Nurse and Chief of NESD for all in-patient units', RNs and LPNs.

The classes on documentation of IV therapy featured lively interchanges between staff and presenters about standardizing documentation. However, standardizing documentation of intravenous therapy led to improved documentation.

Many factors seemed to impact on the problem of insufficent documentation of patient care/progress on the SF 509. First, angry feelings were voiced that the Nursing Notes (SF 510) were taken away and if that form was no longer in use then they (the nurses) perceived that they were not supposed to chart except on the Therapeutic Documentation Care Plans. Second, there was either reluctance, confusion or a lack of understanding about when to write on the progress notes. It seemed that the nursing staff was not comfortable with making the decision about when to document on the SF 509.

The decison was made initially to limit documentation on the SF 509 form to permanent party personnel. After the study was well underway, the non permanent party personnel were allowed to chart. Their documentation was and is being monitored by the RN staff.

Problems with minimum utilization of the Therapeutic Documentation Care Plans could be attributed to a lack of understanding of how TD's could be used to help the staff easily document nursing actions that would translate into factors to be utilized in calculating patient acuity. Also, staff nurses had difficulty expressing nursing orders in terms compatible with the coding system. Consequently, they often did not write key nursing orders. At the same time, ward censuses were high and the clinical head nurses were very busy. Perhaps they could not find the time necessary to identify nursing orders that were standard for nursing care problems frequently identified on a given unit. Decision to Continue With Form Use

In April 1986, a Clinical Nursing Records Study Questionnaire was given to all Department of Nursing personnel who were using the test forms. There were 92 completed questionaires returned and the responses tabulated. In response to the question "Would you prefer to return to the previous method of documentation?" 98 percent responded NO.

This mandate coupled with positive reports from the Nursing Quality Assurance Committee and the finding that no unusual occurences during the test period could be attributed to the study forms was outlined in the project officer's recommendations to continue the study through calendar year 1986. The Chief, Department of Nursing accepted the recommendation and presented her recommendation to the MEDDAC Commander. There was no dissent and the decision was made to continue using the test forms.

Evaluation

Input was collected regarding changes by utilizing the questionnaire discussed in the previous section, and by the project officer and the chief of NESD informally discussing form utilization on the individual units. Staff reactions were generally enthusiastic and positive.

Recommendation

Any form design or guideline changes suggested by personnel at this test site were already presented at the May 86 meeting of Project Officers and the Principal Investigator. However, based on experiences at this site I recommend that one individual, who is knowledgeable about the study forms and writing nursing orders, be totally available to work on a one-to-one basis with head nurses ASAP after implementation of the forms. This person could work with the head nurses to observe patients, the care required and provided,

and documentation of that care. In this manner, suggestions could be made and changes could be initiated immediately. This would serve to reinforce the training provided in classes and to provide real patients and pertinent examples for each unit staff.

In addition, I would establish working groups or committees composed of head nurses, staff nurses, the primary trainer, supervisors and/or other knowledgeable people to work on writing nursing orders specific for problems encountered on a particular unit and/or common to many units. The creation of standard nursing orders that address actions indicated to deal with problems common to many patients could be a time saving measure that would prevent the reinvention of orders by several different individuals. The end result could be improved documentation of care, more time to spend with the patient, and a more satisfied staff.

APPENDIX A

INFORMATION PAPER

SUBJECT, The Clinical Nursing Records Study

ISSUE, To describe a study regarding nursing documentation conducted by the USA Health Care Studies and Clinical Investigation Activity (HCSCIA), Ft Sam Houston, TX. Prepared for Commanders and headquarters' staffs at test sites.

FACTS,

1. In recent years general dissatisfaction has been verbalized within the Army Nurse Corps regarding inpatient nursing documentation. There has been an overwhelming number of requests for overprints and exceptions to policy. A 1981 ad hoc committee for clinical nursing records proposed revisions and recommended testing of revised forms. The study was assigned to HCSCIA as part of the FY 84 AMEDD Study Program. Emphasis was expanded to examine all inpatient forms currently in use at MTFs. The Study Director is COL Marian Walls, ANC, formerly Senior Staff Officer, Nursing Division, HQ HSC, currently, Chief, Department of Nursing, Brooke Army Medical Center. Co-investigators are MAJ Martha Bell, ANC and LTC Terry R. Misener, ANC, Nursing Methods Analysts, HCSCIA.

2. A worldwide survey of Army nursing personnel identified documentation problems. A working group of ANC officers was formed to identify possible changes within the scope of JCAH requirements, ARs, and medical/legal considerations. Representatives from HSC DCCS, PAD, and JAG served as advisors. In addition, proposed changes were coordinated with OTSG PAD, OTSG Publications, and DA TAG to insure that "test" forms are considered parts of the permanent inpatient record. Concomitantly, proposed changes have been reviewed by the JCAH. OTSG Consultants were briefed regarding the study effort and have concurred.

3. The authority for the test is HQDA Letter 40-85-4 "Clinical Nursing Records Study-Test Forms". Five revised and three new forms (Appendix 1) will be tested. SF 509 Progress Notes will be used by nursing personnel during the test. Test forms are authorized for use only at designated sites. The forms will be phased in over a month on all nursing units at each test site, and used for an additional three months. HQDA Letter 40-85-4 authorizes use of the test forms for two years; hence, facilities will have the option to continue using the forms after the testing period. Printing costs will be absorbed by DA; one year's quantity has been ordered to preclude local reproduction of forms and guidelines.

4. Four MTFs (FAMC, and the hospitals at Fts Jackson, Campbell, and Polk) will participate in the study. Hospital staffs will be oriented to the test by project personnel from local Departments of Nursing. Site coordination will be completed through project officers appointed by local Chief Nurses. Your Project Officer is Lieutenant Colonel Lynn Jorgeson.

APPENDIX 1

Clinical Nursing Records Study

Test Forms

REVISED FORMS

DA Form 3888-2 (TEST) Medical Record--Nursing History and Assessment
(revision of DA 3888)

DA Form 3888-4 (TEST) Medical Record--Nursing Care Plan
(revision of DA 3888-1)

DA Form 4256-1 (TEST) Clinical Record--Doctor's Orders for Medications
(revision of DA 4256)

DA Form 4677-1 (TEST) Clinical Record--Therapeutic Documentation Care Plan for Nonmedications
(revision of DA 4677)

DA Form 4678-1 (TEST) Clinical Record--Therapeutic Documentation Care Plan for Medications
(revision of DA 4678)

NEW FORMS

DA Form 3888-3 (TEST) Medical Record--Nursing History and Assessment, continued

DA Form 3888-5 (TEST) Medical Record--Nursing Discharge Summary
(NOTE, a multiple copy form; copies designed to be included in the inpatient and outpatient treatment records and provided as a record of discharge instructions for patient's home use.)

DA Form 4256-2 (TEST) Clinical Record--Doctor's Orders for Nonmedications

HSXV-DN
9 July 1985

INFORMATION PAPER

SUBJECT: The Clinical Nursing Records Study

ISSUE: To describe a study regarding nursing documentation conducted by the USA Health Care Studies and Clinical Investigation Activity (HCSCIA). Ft Sam Houston, TX. Prepared for Department of Nursing personnel at test sites.

FACTS:

1. In recent years general dissatisfaction has been verbalized within the Army Nurse Corps regarding inpatient nursing documentation. There has been an overwhelming number of requests for overprints and exceptions to policy. A 1981 ad hoc committee for clinical nursing records proposed revisions and recommended testing of revised forms. The study was assigned to HCSCIA as part of the FY 84 AMEDD Study Program. Emphasis was expanded to examine all inpatient forms currently in use at MTFs. The Study Director is COL Marian Walls, ANC, formerly Senior Staff Officer, Nursing Division, HQ HSC, currently Chief, Department of Nursing, Brooke Army Medical Center. Co-investigators are MAJ Martha Bell, ANC and LTC Terry R. Misener, ANC, Nursing Methods Analysts, HCSCIA.

2. A worldwide survey of Army nursing personnel identified documentation problems. A working group of ANC officers was formed to identify possible changes within the scope of JCAH Requirements, Army Regulations, and medical-legal considerations. Representatives from HQ HSC Patient Administration Division, Judge Advocate General, and Deputy Chief of Staff for Clinical Services served as advisors. "Test" forms will be part of the permanent inpatient record. Proposed changes and guidelines have been reviewed by the JCAH. OTSG Consultants have been briefed regarding the study effort and have concurred. Commanders of test sites have agreed to testing of forms at their respective facilities.

3. Five revised and three new forms (Appendix 1) will be tested. Revisions involve the nursing history, assessment, and care plan formats (DA Forms 3888 and 3888-1); the use of a coding system on revised Therapeutic Documentation Care Plans (DA Forms 4677 and 4678) to indicate efficacy of intervention; and the separation of nonmedication from medication orders on the physician's order sheets (DA Form 4256). Chart dividers will be provided to separate medication from nonmedication orders, with necessary "pull tabs" to enable care providers to "flag" newly written orders. Transcription of certain orders to revised Therapeutic Documentation sheets will no longer be required because of the format of the order sheets. New forms to be introduced are a nursing discharge summary and nursing history/assessment continuation form. Nursing personnel will use the SF 509 Progress Notes rather than SF 510 Nursing Notes during the test period.

4. All Department of Nursing personnel and other hospital staff will be

oriented to test forms and guidelines by study personnel from local Departments of Nursing. The forms will be phased in over a month on all nursing units at each test site and used for an additional three months. Following the testing period, personnel will be asked to assess various aspects of the forms and guidelines. Facilities will have the option to continue using the forms after the testing period.

5. Four medical treatment facilities (Fitzsimons Army Medical Center, and the hospitals at FTs Jackson, Campbell and Polk) will participate in the study effort. Test forms are authorized for use ONLY at designated sites. Project officers from the Departments of Nursing have been appointed by local Chief Nurses. Questions or issues concerning the test forms are to be directed to your Project Officer who is LTC Jorgeson 3660/3148.

HSHN-H
1 August 1985

INFORMATION PAPER

SUBJECT, The Clinical Nursing Records Study

ISSUE, To describe a study regarding nursing documentation conducted by the USA Health Care Studies and Clinical Investigation Activity (HCSCIA), Ft Sam Houston, TX. Prepared for MC, AMSC, and MSC officers at test sites.

FACTS,

1. In recent years general dissatisfaction has been verbalized within the Army Nurse Corps regarding inpatient nursing documentation. There has been an overwhelming number of requests for overprints and exceptions to policy. A 1981 ad hoc committee for clinical nursing records proposed revisions and recommended testing of revised forms. The study was assigned to HCSCIA as part of the FY 84 AMEDD Study Program Emphasis was expanded to examine all inpatient forms currently in use at MTFs.

2. A worldwide survey of Army nursing personnel identified documentation problems. A working group of ANC officers was formed to identify possible changes within the scope of JCAH requirements, Army Regulations, and medical-legal considerations. Representatives from HQ HSC Patient Administration Division, Judge Advocate General, and Deputy Chief of Staff for Clinical Services served as advisors. Proposed changes and guidelines were reviewed by the JCAH. OTSG Consultants were briefed regarding the study effort and have concurred. Commanders of all test sites agreed to testing of forms at their respective facilities.

3. Five revised and three new forms will be tested. Revisions involve the nursing history, assessment and care plan formats (DA Forms 3888 and 38881); the use of a coding system on revised Therapeutic Documentation Care Plans (DA Forms 4677 and 4678) to indicate efficacy of intervention; and the separation of nonmedication from medication orders on the physician's order sheets (DA Form 4256). Chart dividers will be provided to separate medication from nonmedication orders, with necessary "pull tabs" to enable care providers to "flag" newly written orders. New forms to be introduced are a nursing discharge summary and nursing history/assessment continuation form. Nursing personnel will use the SF 509 Progress Notes rather than SF 510 Nursing Notes during the test period. "Test" forms will be part of the permanent inpatient record.

4. Hospital staffs will be oriented to test forms and guidelines by project personnel from local Departments of Nursing. The forms will be phased in over a month on all nursing units at each test site and used for an additional three months. Following the testing period, personnel will be asked to assess various aspects of the forms and guidelines. Facilities will have the option to continue using the forms after the testing period.

5. Four medical treatment facilites (Fitzsimons Army Medical Center, and the hospitals at FTs Jackson, Campbell and Polk) will participate in the study effort. Project officers from the Departments of Nursing have been appointed by local Chief Nurses. Questions or issues concerning the test forms are to be directed to your Project Officer who is LTC Lynn Jorgeson/3148.

HSHN-H
1 August 1985

INFORMATION PAPER

SUBJECT, The Clinical Nursing Records Study

ISSUE, To describe a study regarding nursing documentation conducted by the USA Health Care Studies and Clinical Investigation Activity (HCSCIA), Ft Sam Houston, TX. Prepared for Patient Administration Division personnel at test sites.

FACTS,

1. In recent years general dissatisfaction has been verbalized within the Army Nurse Corps regarding inpatient nursing documentation. There has been an overwhelming number of requests for overprints and exceptions to policy. A 1981 ad hoc committee for clinical nursing records proposed revisions and recommended testing of revised forms. The study was assigned to HCSCIA as part of the FY 84 AMEDD Study Program Emphasis was expanded to examine all inpatient forms currently in use at MTFs.

2. A worldwide survey of Army nursing personnel identified documentation problems. A working group of ANC officers was formed to identify possible changes within the scope of JCAH requirements, ARs, and medical-legal considerations. Representatives from the HQ HSC PAD, JAG, and Deputy Chief of Staff for Clinical Services served as advisors. In addition, proposed changes have been coordinated with OTSG PAD, OTSG Publications, and DA TAG to insure that "test" forms are considered parts of the permanent inpatient record. Proposed changes and guidelines were reviewed by the JCAH. OTSG Consultants were briefed regarding the study effort and have concurred. Commanders of test sites have agreed to allow testing of forms at their respective facilities.

3. The authority for the test is HQDA Letter 40-85-4 "Clinical Nursing Records Study-Test Forms". Five revised and three new forms (Appendix 1) will be tested. Forms are authorized for use ONLY at test sites. Nursing personnel will use SF 509 Progress notes to record narrative notations usually found on the SF 510 Nursing Notes. SF 510 will not be used during the period of the test.

4. Hospital staffs will be oriented by study personnel from local Departments of Nursing. The forms will be phased in over a month on all nursing units at each test site, and used for an additional three months. HQDA Letter 40-85-4 authorizes use of the test forms for two years; hence, facilities will have the option to continue using the forms after the testing period. One year's quantity has been ordered to preclude local reproduction of forms or guidelines.

5. Four medical treatment facilities (Fitzsimons Army Medical Center, and the

hospitals at FTs Jackson, Campbell and Polk) will participate in the study. The costs of printing all forms and accompanying guidelines will be absorbed by DA. Guidelines will be provided to medical records personnel at test sites. Project officers from the Departments of Nursing have been appointed by local Chief Nurses. Questions or issues concerning the test forms are to be directed to your Project Officer who is LTC Lynn Jorgeson/3148.

Appendix B

Clinical Nursing Records Study - Forms Management

HSXV-DN Clinical Nursing Records Study - Forms Management

TO SEE DISTRIBUTION

FROM Project Officer

9 Jan 86
LTC Meyers/td/3148

1. The Clinical Nursing Records Study is scheduled to begin 21 January 86. Chart dividers will be distributed to all in-patient units based on operating beds. The test forms and forms in current use will be managed as follows:

2. Mr. Clear, in publications will control all blank forms. The initial supply of over-printed doctors order sheets will be distributed where appropriate, during the week prior to 21 January 86. These forms will be controlled by the Project Officer.

3. The rubber stamps on order for use with the therapeutic documentation care plans are projected to arrive next week. These stamps will be distributed to the users ASAP.

4. When requesting issue of forms, please separate requests for test forms from non-test forms on seperate DA 17's.

5. At the time of pick-up of test forms, NCOIC's will turn in unopened packages of the following forms to Mr. Clear. He will store these forms until a decision is made to discontinue or continue the study. Turn in DA Forms 3888, 3888-1, 4256, 4677 and 4678. Loose copies of the above forms are to be maintained on the in-patient units to be used in charts of patients admitted prior to 21 January 86 who will be discharged before 4 February 86. On 4 February all remaining loose copies should be destroyed. At that time all charts will be converted to the test forms.

6. Distribution of test forms and turn-in of old forms will proceed as follows from 0800-1600:

a.	Clinical Support and Operating Room	Tuesday January 14th (DA Forms 4256-1 and 4256-1)
b.	Clinical Nursing Section II	Wednesday January 15th
c.	Clinical Nursing I	Thursday January 16th
d.	Ambulatory Care Section	Friday January 17th

Adherence to the above schedule by ward, clinic, NCOICs will be most appreciated.

HSXV-DN

SUBJECT: Clinical Nursing Records Study - Forms Management CMT I

7. Any questions about the management of test forms should be directed to the project officer or SFC Kaas.

/s/SHARLEEN G. MEYERS
LTC, ANC
Project Officer CNR Study

DISTRIBUTION:

C, DON	Wardmasters
Asst C, DON	Clinic NCOIC's
C, Publications	C, NETS
Mr. Clear	LT Peterson
Section Supervisors	All Head Nurses

APPENDIX C

FORM UTILIZATION - UNIT "1"

YES	NO	NA	% COMPLIANCE	INTERNAL NURSING AUDIT SHEET
79	3	4	97	1. Doctor's orders taken off by paraprofessionals or ward clerk verified by RN's initials in the appropriate box on DA Form 4677 and DA Form 4678.
79	12	0	87	2. TPR Graphic SF 511 filled out properly to include admitting vital signs.
75	11	0	88	3. DA Form 3888-2 (Test) completely filled out as well as signed by RN within 24 hours of admission.
79	12	0	87	4. DA Form 3888-4 (Test) initiated by RN within 24 hours of admission.
62	6	23	91	5. If DA Form 3888-2 (Test) is not completed on admission is there an admission note on SF 509, in SOAP format, including age, race, general condition, sex, history and pertinent physical assessment data?
37	3	51	92	6. Allergies underlined in red pencil and sticker on front of chart.
70	21	0	77	7. Problem list must include date and initial of RN identifying problem. All problems numbered.
66	25	0	73	8. Nursing orders reflect problem list and are initiated by RN. Numbered by problem.
75	3	13	96	9. Nursing notes on SF 509 reflect changes in patients' response; notes are not repetitious or stating normal responses.
49	13	29	79	10. NCP and appropriate problem numbers(s) are used with SOAP notes. Other notes are prefaced by: Nursing Note or Nursing Entry.
83	8	0	91	11. Doctor's orders taken off correctly and written on the correct documentation sheet. Single action orders accounted for correctly.
51	14	26	78	12. Results of PRN meds/procedures are charted using the results codes; omitted, ineffective or abnormal results have a SOAP note on the SF 509.
81	10	0	89	13. DA Form 4677 and DA Form 4678 are filled out correctly and completely.
33	11	47	75	14. Results of single action orders that can be evaluated are documented on the SF 509 in SOAP format.
28	4	59	87	15. DA Form 3888-5, Discharge Instructions initiated or completed and signed by RN. Cross reference made on SF 509 on discharge.

FORM UTILIZATION - UNIT "2"

YES	NO	NA	% COMPLIANCE	INTERNAL NURSING AUDIT SHEET
73	7	6	91	1. Doctor's orders taken off by paraprofessionals or ward clerk verified by RN's initials in the appropriate box on DA Form 4677 and DA Form 4678.
65	21	0	75	2. TPR Graphic SF 511 filled out properly to include admitting vital signs.
75	11	0	87	3. DA Form 3888-2 (Test) completely filled out as well as signed by RN within 24 hours of admission.
71	12	3	85	4. DA Form 3888-4 (Test) initiated by RN within 24 hours of admission.
23	3	60	88	5. If DA Form 3888-2 (Test) is not completed on admission is there an admission note on SF 509, in SOAP format, including age, race, general condition, sex, history and pertinent physical assessment data?
24	5	57	83	6. Allergies underlined in red pencil and sticker on front of chart.
72	14	3	84	7. Problem list must include date and initial of RN identifying problem. All problems numbered.
64	17	5	79	8. Nursing orders reflect problem list and are initiated by RN. Numbered by problem.
72	0	14	100	9. Nursing notes on SF 509 reflect changes in patients' response; notes are not repetitious or stating normal responses.
56	11	19	84	10. NCP and appropriate problem numbers(s) are used with SOAP notes. Other notes are prefaced by: Nursing Note or Nursing Entry.
80	6	0	93	11. Doctor's orders taken off correctly and written on the correct documentation sheet. Single action orders accounted for correctly.
42	11	33	79	12. Results of PRN meds/procedures are charted using the results codes; omitted, ineffective or abnormal results have a SOAP note on the SF 509.
82	3	1	96	13. DA Form 4677 and DA Form 4678 are filled out correctly and completely.
28	7	51	80	14. Results of single action orders that can be evaluated are documented on the SF 509 in SOAP format.
40	3	43	93	15. DA Form 3888-5, Discharge Instructions initiated or completed and signed by RN. Cross reference made on SF 509 on discharge.

FORM UTILIZATION ,NIT "3"

YES	NO	NA	% COMPLLA#CE	lNTE##AL NURSING AUD#T SHEET
65	3	4	96	1. Doctor's orders taken off by paraprofessiunals or ward clerk verified bv RN's initials in the appropriate box on DA Form 4677 and DA Form 4678.
68	4	0	94	2. TPR Graphic SF 511 filled out properly to include admitting vital signs.
68	4	0	94	3. DA Form 3888-2 (Test) completely filled out as well as signed by RN within 24 hours of admission.
69	3	0	96	4. DA Form 3888-4 (Test) initiated bv RN within 24 hours of admission.
15	3	54	83	5. lf DA Form 3888-2 (Test) is not completed on admission is there an admission note on SF 509, in SOAP format, including age, race, general condition, sex, history and pertinent physical assessment data?
12	1	59	92	6. Allergies underlined in red pencil and sticker on front of chart.
62	5	0	93	7. Problem list must include date and initial of RN identifying problem. All problems numbered.
62	7	3	90	8. Nursing orders reflect problem list and are initiated by RN. Numbered bv problem.
63	6	3	91	9. Nursing notes on SF 509 reflect changes in patients' response; notes are not repetitious or stating normal responses.
56	8	8	91	10. NCP and appropriate problem numbers(s) are used with SOAP notes Other notes arc pretaceo by: Nursino Note or Nursing Entrv.
71	1	0	99	11. Doctor's orders taken off correctlv and written on the correct documentation sheet. Single action orders accounted for correctly.
27	1C	13	73	12. Results of PRN meds/procedures are charted using the results codes; omitted, ineffective or abnormal results have a SOAP note on the SF 509.
70	2	0	97	13. DA Form 4677 and DA Form 4678 are filled out correctly and completely.
37	6	29	86	14. Results of single action orders that can be evaluated are documented on the SF 509 in SOAP format.
27	2	43	93	15. DA Form 3888-5, Discharge Instructions initiated or completed and signed by RN. Cross reference made on SF 509 on discharge.

FORM UTILIZATION - UNIT "4"

YES	NO	NA	% COMPLIANCE	INTERNAL NURSING AUDLT SHEET
54	7	11	89	1. Doctor's orders taken off by paraprofessionals or ward clerk verified by RN's initials in the appropriate box on DA Form 4677 and DA Form 4678.
60	12	0	83	2. TPR Graphic SF 511 filled out properly to include admitting vital signs.
66	6	0	92	3. DA Form 3888-2 (Test) completely filled out as well as signed by RN within 24 hours of admission.
72	0	0	97	4. DA Form 3888-4 (Test) initiated by RN within 24 hours of admission.
29	8	35	78	5. If DA Form 3888-2 (Test) is not completed on admission is there an admission note on SF 509, in SOAP format, including age, race, general condtiion, sex, history, and pertinent physical assessment data.
26	1	45	96	6. Allergies underlined in red pencil and sticker on front of chart.
66	6	0	92	7. Problem list must include data and initial of RN identifying problem. All problems numbered.
60	12	0	83	8. Nursing orders reflect problem list and are initiated by RN. Numbered by problem.
56	6	10	90	9. Nursing notes on SF 509 reflect changes in patients' response; notes are not repetitious or stating normal responses.
51	7	14	89	10. NCP and appropriate problem numbers(s) are used with SOAP notes. Other notes are prefaced by: Nursing Note or Nursing Entry.
70	2	0	97	11. Doctor's orders taken off correctly and written on the correct documentation sheet. Single action orders accounted for correctly.
40	9	23	81	12. Results of PRN meds/procedures are charted using the results codes; omitted, ineffective or abnormal results have a SOAP note on the SF 509.
62	10	0	86	13. DA Form 4677 and DA Form 4678 are filled out correctly and completely.
39	7	26	85	14. Results of single action orders that can be evaluated are documented on the SF 509 in SOAP format.
28	0	44	100	15. DA Form 3888-5, Discharge Instructions initiated or completed and signed by RN. Cross reference made on SF 509 on discharge.

APPENDIX H

Methodology Phase IV

Surveys

Case # 1_____
(1-5)

DEPARTMENT OF THE ARMY
US ARMY HEALTH CARE STUDIES AND CLINICAL INVESTIGATION ACTIVITY
FORT SAM HOUSTON, TEXAS 78234

HSHN-H

23 June 1986

Dear Nurse Colleague:

1. For the past several months you have been testing new forms and concepts of nursing documentation as part of the Clinical Nursing Records Study. The study was designed to develop a less cumbersome, more integrated and satisfactory alternative documentation system reflecting the AMEDD Standards of Nursing Practice and JCAH requirements. Your enthusiasm and willingness to be an integral part of this effort has been greatly appreciated by the investigators.

2. We are now moving into the the evaluation phase, a key portion of which is to assess your satisfaction with the test forms and system of documentation. You are asked to respond to the following questions by comparing the items you "tested" with the manner in which you documented "before" the test forms. Recall that the test forms were a change in the way you "did business," and consequently, it took time to learn the new methods. As you answer, reflect on how you feel TODAY.

3. Your comments are crucial to the completion of this study. Changes to guidelines and forms design will be based upon your responses. If changes are adapted for worldwide use, your experience and comments will be invaluable to other personnel. Copies of the final study report will be provided to test site chief nurses.

4. Thank you in advance for your assistance in this important study.

Sincerely,

Martha R. Bell

Martha R. Bell
LTC, ANC
Principal Investigator

CLINICAL NURSING RECORDS STUDY
DEPARTMENT OF NURSING PERSONNEL
SATISFACTION SURVEY

(R)

********** ********** **********

It is neither the intent nor will it be possible, to identify any one individual's responses in the final report. Do not place your name or any identifying information on the questionnaire. The control number on the first page of the survey (upper right hand corner) is to enable a clerk to account for a returned copy. The principal investigator will receive your questionnaire after it has been returned to Fort Sam Houston and removed from the envelope. Completion of the questionnaire will be considered your consent to participate. Should you desire not to participate, please return the uncompleted questionnaire in the provided envelope to the project officer designated at your medical treatment facility.

********** ********** **********

Unless instructed to do otherwise in the following sections, please answer all questions by circling the numbered response that most closely reflects your opinion, or by writing in the information requested. If a question is unanswered, the investigator will assume you did not have enough experience with the tested documentation system to comment on that particular aspect. You will be provided the opportunity to make written comments at the end of the questionnaire. Do not make written entries by the questions. They may be overlooked during coding procedures.

SECTION A

"OVERALL, WHEN I COMPARE THE OLD SYSTEM OF DOCUMENTATION WITH THE ONE WE ARE TESTING, I FEEL THE TEST FORMS AND INTEGRATED PROGRESS NOTES . . ."

	STRONGLY AGREE	AGREE	DISAGREE	STRONGLY DISAGREE	DO NOT USE THIS SPACE
1. Save nursing documentation time.	1	2	3	4	(6)
2. Help to avoid writing the same information several different places.	1	2	4	4	(7)
3. Improve communications concerning the patient among nursing personnel.	1	2	3	4	(8)
4. Improve communications concerning the patient between nurses and other health care professionals, including physicians.	1	2	3	4	(9)

"OVERALL, WHEN I COMPARE THE OLD SYSTEM OF DOCUMENTATION WITH THE ONE WE ARE TESTING, I FEEL THE TEST FORMS AND INTEGRATED PROGRESS NOTES . . ." (R)

		STRONGLY AGREE	AGREE	DISAGREE	STRONGLY DISAGREE	
5.	Encourage me to use the nursing process.	1	2	3	4	(10)
6.	Are easier to use.	1	2	3	4	(11)
7.	Should have been a more drastic change from the old system of documentation.	1	2	3	4	(12)
8.	Are a definite improvement.	1	2	3	4	(13)
9.	Provide me a better picture of what is happening to the patient.	1	2	3	4	(14)
10.	Reduce the amount of paperwork I have to do.	1	2	3	4	(15)
11.	Have improved the quality of documentation on my nursing unit.	1	2	3	4	(16)

SECTION B

NURSING HISTORY AND ASSESSMENT (DA Form 3888-2 Test)
NURSING HISTORY AND ASSESSMENT CONTINUATION FORM (DA Form 3888-3 Test)
NURSING CARE PLAN (DA Form 3888-4 Test)

		STRONGLY AGREE	AGREE	DISAGREE	STRONGLY DISAGREE	
1.	The number of nursing history questions is adequate.	1	2	3	4	(17)
2.	The content of the nursing history questions is as thorough as I need them to be.	1	2	3	4	(18)

****

"ON MY NURSING UNIT . . ."

3.	The block for patient's personal articles and valuables is helpful.	1	2	3	4	(19)

	STRONGLY AGREE	AGREE	DISAGREE	STRONGLY DISAGREE	(R)
"ON MY NURSING UNIT . . ."					
4. Most nursing <u>histories</u> are done by non-RN/ANC personnel.	1	2	3	4	(20)
5. <u>All</u> nursing <u>assessments</u> are done by RNs and ANCs.	1	2	3	4	(21)
6. An overprint is used for the assessment.	1	2	3	4	(22)
7. We often use the history and assessment continuation sheet.	1	2	3	4	(23)
**********					
"OVERPRINTING THE ASSESSMENT CATEGORIES FROM THE STANDARDS OF NURSING PRACTICE (DA PAM 40-5) . . ."					
8. Is helpful to me.	1	2	3	4	(24)
9. Has increased my use of the categories.	1	2	3	4	(25)
10. Should be continued.	1	2	3	4	(26)
**********					
11. I like the idea of the nursing history and assessment, if completed on admission, serving as the admission nursing note.	1	2	3	4	(27)
**********					
"OVERPRINTING THE NURSING DIAGNOSES ONTO THE CARE PLAN . . ."					
12. Is helpful to me.	1	2	3	4	(28)
13. Has increased my use of the diagnoses.	1	2	3	4	(29)
14. Should be continued.	1	2	3	4	(30)

SECTION C

(R)

NURSING DISCHARGE SUMMARY (DA Form 3888-5 Test)

		STRONGLY AGREE	AGREE	DISAGREE	STRONGLY DISAGREE	
1.	Elements on the form are those I would include in a discharge nursing note.	1	2	3	4	(34)
2.	I like to have the discharge summary serve as the nursing discharge note.	1	2	3	4	(35)
3.	It is helpful to have a copy for the patient.	1	2	3	4	(36)
4.	It is important for a nursing summary to appear in the outpatient record.	1	2	3	4	(37)
5.	The nursing discharge summary form needs to be kept in the system.	1	2	3	4	(38)
6.	Discharge summaries should be in a multidisciplinary format so physicians and other health care providers (e.g., dietitian, PT, etc.) could make appropriate notations.	1	2	3	4	(39)

SECTION D

DOCTOR'S ORDERS MEDICATION/DOCTOR'S ORDERS NONMEDICATION (DA Form 4256-1 Test; DA Form 4256-2 TEST)

		STRONGLY AGREE	AGREE	DISAGREE	STRONGLY DISAGREE	
1.	We frequently use the buff copy of the order sheets on my nursing unit.	1	2	3	4	(40)
2.	I like not having to recopy some single action orders onto the Therapeutic Documentation Care Plans.	1	2	3	4	(41)

	STRONGLY AGREE	AGREE	DISAGREE	STRONGLY DISAGREE	(R)
3. Having doctor's orders separated onto medication and nonmedication sheets has caused minimal difficulty for me.	1	2	3	4	(60)
4. Doctor's orders should remain separated on color coded medication and nonmedication sheets.	1	2	3	4	(61)

****

"IF WE WENT BACK TO THE 'OLD' ORDER SHEETS (ALL ORDERS ON ONE SHEET) . . ."

5. I would have no difficulty identifying completed single action orders.	1	2	3	4	(65)
6. I would still want a column for single action orders to preclude my having to recopy them onto the Therapeutic Documentation Care Plans.	1	2	3	4	(66)

****

SECTION E

THERAPEUTIC DOCUMENTATION CARE PLANS (TDs), MEDICATION AND NONMEDICATION (DA Form 4677-1 Test; DA Form 4678-1 Test)

	STRONGLY AGREE	AGREE	DISAGREE	STRONGLY DISAGREE	
1. I like being able to document (with effectiveness codes or key words) the patient's response directly on the TDs.	1	2	3	4	67)

****

		STRONGLY AGREE	AGREE	DISAGREE	STRONGLY DISAGREE	(R)
"RECORDING THE PATIENT'S RESPONSE ON THE THERAPEUTIC DOCUMENTATION CARE PLANS . . ."						
2.	Improves my documentation of patient care.	1	2	3	4	(70)
3.	Encourages me to write more nursing orders to describe nursing activities with the patient.	1	2	3	4	(71)
4.	Improves communication among nursing personnel.	1	2	3	4	(72)
5.	Improves communication between nurses and other health care providers.	1	2	3	4	(73)
6.	Has decreased fragmented documentation in the record.	1	2	3	4	(74)
7.	Allows me to give a more thorough report.	1	2	3	4	(75)
8.	Gives me a better "picture" of what happened to the patient.	1	2	3	4	(76)
	**********					
9.	I did not document patient responses on the TDs.	1	2	3	4	(77)
10.	I had minimal difficulty recording the patient's responses on the TDs.	1	2	3	4	(78)
11.	The expanded use of the TDs (being able to document responses) is a concept which should be available to all nursing personnel worldwide.	1	2	3	4	(79)

****

		STRONGLY AGREE	AGREE	DISAGREE	STRONGLY DISAGREE	(R)
"THE 'FOLDER' TYPE FORMAT . . ."						
12.	Is an improvement.	1	2	3	4	(30)
13.	Should be kept even if it cannot be overprinted with orders.	1	2	3	4	(31)
14.	Should have the patient identification block printed on all pages.	1	2	3	4	(32)
	**********					
15.	I like the sturdier paper on which the forms are printed.	1	2	3	4	(33)
16.	Having separate pages for recurring, delayed, or prn action orders is helpful to me.	1	2	3	4	(34)
17.	To my knowledge, there were no treatment or medication errors committed on my nursing unit which could be blamed on the new format of the TDs.	1	2	3	4	(35)
18.	I would prefer to have the TDs in a single sheet format (like the "old" TDs) even knowing that I would have less room for documentation.	1	2	3	4	(36)
19.	If a single sheet format were to be used, I would prefer a medium weight paper (less bulky than the tested paper).	1	2	3	4	(37)
20.	All medication and non-medication forms should remain color-coded.	1	2	3	4	(38)
21.	Yellow highlighter use should be reinstated to discontinue orders.	1	2	3	4	(39)

SECTION F

(R)

INTEGRATED PROGRESS NOTES (SF 509)

		STRONGLY AGREE	AGREE	DISAGREE	STRONGLY DISAGREE	
"THE INTEGRATED PROGRESS NOTE . . ."						
1.	Improves communications concerning the patient among all health care providers.	1	2	3	4	(9
2.	Has encouraged me to be more thorough in documentation.	1	2	3	4	(9
3.	Has encouraged me to be more concise in documentation.	1	2	3	4	(9
4.	Lessens fragmenting of information in the patient record.	1	2	3	4	(9
5.	Lessens the amount of information everyone must document.	1	2	3	4	(9
6.	Has saved me time in documenting. (I feel I don't need to repeat information previously documented by another health care provider because it's all in the same place).	1	2	3	4	(9
7.	Encourages me to read other care providers' notes.	1	2	3	4	(9
8.	Should be used at all Army hospitals.	1	2	3	4	(9
	**********					
9.	I had no difficulty distinguishing nursing notations from tnose of other disciplines.	1	2	3	4	(10
10.	Physicians on my nursing unit seemed to like having narrative nursing comments integrated with other patient care documentation.	1	2	3	4	(10

	STRONGLY AGREE	AGREE	DISAGREE	STRONGLY DISAGREE	(R)
11. Other health care providers (e.g., physical therapist, dietitian, social worker,) seemed to like having narrative nursing comments integrated with other patient care documentation.	1	2	3	4	(104)
12. Although the guidelines read that all nursing personnel were authorized to chart on the progress notes, there were some exceptions to this policy on my nursing unit.	1	2	3	4	(105)

SECTION G

1. "IN MY OPINION, THE BOTTOM LINE TO EVERYTHING WE HAVE TESTED IS . . ." (circle ONE code)

CODE # 1 = The system should be implemented exactly as tested.

2 = We should go back to the "old" way and not use any of the tested elements. (106)

3 = The system should be implemented with some modifications (please specify below).

a. General Comments: (107-110)

b. DA Form 3888-2 Test: (111-114)

c. DA Form 3888-3 Test: (115-118)

d. DA Form 3888-4 Test: (119-122)

e. DA Form 3888-5 Test: (123-126)

(R)

f. DA Form 4256-1 Test: (127-130)

g. DA Form 4256-2 Test: (131-134)

h. DA Form 4677-1 Test: (135-138)

i. DA Form 4678-1 Test: (139-142)

j. Integrated Progress Notes: (143-146)

SECTION H

PROFESSIONAL DATA

This section concerns your professional and military background. To assist us in analysis, please answer each item.

1. My current duty assignment is as: (circle ONE code; if you are assigned to two areas, e.g. Staff Nurse/Infection Control, select your primary area of responsibility) (147,148)

CODE # 01 = Clinical Staff Nurse
02 = Clinical Head Nurse
03 = Clinical Nurse Specialist
04 = Specialty Practices (includes Midwifery, Anesthesiology, etc.)
05 = Section Supervisor (includes Evening/Night Supervision)
06 = Chief Nurse/Assistant Chief Nurse/Nursing Education and Staff Development/Quality Assurance/Infection Control
07 = Other (please specify) _____

2. "MY PRIMARY INPATIENT NURSING UNIT IS . . ." (R
(circle ONE code)

CODE # 1 = Surgical Unit
2 = Psychiatric Unit
3 = Medical Unit
4 = Combined Medical/Surgical Unit (
5 = Pediatric Unit
6 = Critical Care (all ICUs)
7 = L&D, NBN, Ante/Post-Partum
8 = OR/Anesthesia
9 = Other (please specify) _____
0 = Does Not Apply

3. Number of years worked as an RN: (two digits) (151,
(one through six months, enter "00",
seven through 12 months, enter "01",
two years, enter "02", etc.)

4. Number of years worked with Army inpatient medical records/documentation: (two digits) (154,
(one through six months, enter "00",
seven through 12 months, enter "01",
two years, enter "02", etc.)

5. If there are any comments you would like to add about the information requested in this survey, the test forms, or documentation in general, please do so in the following space.

If more space is needed, please staple your responses to this questionnaire.

Thank you for your assistance!

Case # 2 ____
(1-5)

DEPARTMENT OF THE ARMY
US ARMY HEALTH CARE STUDIES AND CLINICAL INVESTIGATION ACTIVITY
FORT SAM HOUSTON, TEXAS 78234

HSHN-H

23 June 1986

To Department of Nursing Personnel:

1. For the past several months you have been testing new forms and concepts of nursing documentation as part of the Clinical Nursing Records Study. The study was designed to develop a less cumbersome, more integrated and satisfactory alternative documentation system. Your enthusiasm and willingness to be an integral part of this effort has been greatly appreciated by the investigators.

2. We are now moving into the the evaluation phase, a key portion of which is to assess your satisfaction with the test forms and system of documentation. You are asked to respond to the following questions by comparing the items you "tested" with the manner in which you documented "before" the test forms. Recall that the test forms were a change in the way you "did business," and consequently, it took time to learn the new methods. As you answer, reflect on how you feel TODAY.

3. Your comments are crucial to the completion of this study. Changes to guidelines and forms design will be based upon your responses. If changes are adapted for worldwide use, your experience and comments will be invaluable to other personnel. Copies of the final report will be provided to test site chief nurses.

4. Thank you in advance for your assistance in this important study.

Sincerely,

Martha R. Bell

Martha R. Bell
LTC, ANC
Principal Investigator

CLINICAL NURSING RECORDS STUDY
DEPARTMENT OF NURSING PERSONNEL
SATISFACTION SURVEY

N

********** ********** **********

It is neither the intent, nor will it be possible, to identify any one individual's responses in the final report. Do not place your name or any identifying information on the questionnaire. The control number on the front page of the survey (upper right hand corner) is to enable a clerk to account for a returned copy. The principal investigator will receive your questionnaire after it has been returned to Fort Sam Houston and removed from the envelope. Completion of the questionnaire will be considered your consent to participate. Should you desire not to participate, please return the uncompleted questionnaire in the provided envelope to the project officer designated at your medical treatment facility.

********** ********** **********

Unless instructed to do otherwise in the following sections, please answer all questions by circling the numbered response that most closely reflects your opinion, or by writing in the information requested. If a question is unanswered, the investigator will assume you did not have enough experience with the tested documentation system to comment on that particular aspect. You will be provided the opportunity to make written comments at the end of the questionnaire. Do not write entries by the questions. They may be overlooked during coding procedures.

SECTION A

"OVERALL, WHEN I COMPARE THE OLD SYSTEM OF DOCUMENTATION WITH THE ONE WE ARE TESTING, I FEEL THE TEST FORMS AND INTEGRATED PROGRESS NOTES . . ."

	STRONGLY AGREE	AGREE	DISAGREE	STRONGLY DISAGREE	DO NOT USE THIS SPACE
1. Save nursing documentation time.	1	2	3	4	(5
2. Help to avoid writing the same information several different places.	1	2	3	4	(7
3. Improve communications concerning the patient among nursing personnel.	1	2	3	4	(8
4. Improve communications concerning the patient between nurses and other health care professionals, including physicians.	1	2	3	4	9

"OVERALL, WHEN I COMPARE THE OLD SYSTEM OF DOCUMENTATION WITH THE ONE WE ARE TESTING, I FEEL THE TEST FORMS AND INTEGRATED PROGRESS NOTES . . ."

		STRONGLY AGREE	AGREE	DISAGREE	STRONGLY DISAGREE	
5.	Are easier to use.	1	2	3	4	(11
6.	Should have been a more drastic change from the old system of documentation.	1	2	3	4	(12)
7.	Are a definite improvement.	1	2	3	4	(13)
8.	Provide me a better picture of what is happening to the patient.	1	2	3	4	(14)
9.	Reduce the amount of paperwork I have to do.	1	2	3	4	(15)
10.	Have improved the quality of documentation on my nursing unit.	1	2	3	4	(16)

SECTION B

NURSING HISTORY AND ASSESSMENT (DA Form 3888-2 Test)
NURSING HISTORY AND ASSESSMENT CONTINUATION FORM (DA Form 3888-3 Test)
NURSING CARE PLAN (DA Form 3888-4 Test)

		STRONGLY AGREE	AGREE	DISAGREE	STRONGLY DISAGREE	
1.	The number of nursing history questions is adequate.	1	2	3	4	(17)
2.	The content of the nursing history questions is as thorough as I need them to be.	1	2	3	4	(18)

****

"ON MY NURSING UNIT . . ."

3.	The block for patient's personal articles and valuables is helpful.	1	2	3	4	(19)
4.	Most nursing <u>histories</u> are done by non-RN/ANC personnel.	1	2	3	4	(20)

"ON MY NURSING UNIT . . ."	STRONGLY AGREE	AGREE	DISAGREE	STRONGLY DISAGREE	(N
5. All nursing assessments are done by RNs and ANCs.	1	2	3	4	(2
6. We often use the history and assessment continuation sheet.	1	2	3	4	(2

****

7. I read the nursing care plan to learn the overall goals for the patient.	1	2	3	4	(3

SECTION C

NURSING DISCHARGE SUMMARY (DA Form 3888-5 Test)

"OTHER THAN THE PATIENT IDENTIFICATION STAMP . . ."	STRONGLY AGREE	AGREE	DISAGREE	STRONGLY DISAGREE	
1. I have completed some portions of the nursing discharge summary for the nurses.	1	2	3	4	(3
2. The entire nursing discharge summary is completed only by an RN/ANC on my nursing unit.	1	2	3	4	(3

SECTION D

DOCTOR'S ORDERS MEDICATION/DOCTOR'S ORDERS NONMEDICATION (DA Form 4256-1 Test/DA Form 4256-2 Test)

	STRONGLY AGREE	AGREE	DISAGREE	STRONGLY DISAGREE	
1. We frequently use the buff copy of the order sheets on my nursing unit.	1	2	3	4	(
2. I like not having to recopy some single action orders onto the Therapeutic Documentation Care Plans.	1	2	3	4	(

		STRONGLY AGREE	AGREE	DISAGREE	STRONGLY DISAGREE	N
3.	Having doctor's orders separated onto medication and nonmedication sheets has caused minimal difficulty for me.	1	2	3	4	(6:
4.	Doctor's orders should remain separated on color-coded medication and nonmedication sheets.	1	2	3	4	(6:

****

"IF WE WENT BACK TO THE 'OLD' ORDER SHEETS (ALL ORDERS ON ONE SHEET) . . ."

5.	I would have no difficulty identifying completed single action orders.	1	2	3	4	(6:
6.	I would still want a column for single action orders to preclude my having to recopy them onto the Therapeutic Documentation Care Plans.	1	2	3	4	(6:

****

SECTION E

THERAPEUTIC DOCUMENTATION CARE PLANS, MEDICATION AND NONMEDICATION (DA Form 4677-1 Test; DA Form 4678-1 Test)

		STRONGLY AGREE	AGREE	DISAGREE	STRONGLY DISAGREE	
1.	I like being able to document (with effectiveness codes or key words) the patient's response directly on the TDs.	1	2	3	4	(67)
2.	Most of my documentation is recorded on the TDs.	1	2	3	4	(68)
3.	In the past, I used to do most of my documenting on the Nursing Notes (SF 510).	1	2	3	4	(69)

		STRONGLY AGREE	AGREE	DISAGREE	STRONGLY DISAGREE	N)
"RECORDING THE PATIENT'S RESPONSE ON THE THERAPEUTIC DOCUMENTATION CARE PLANS . . ."						
4.	Improves my documentation of patient care.	1	2	3	4	(7
5.	Improves communication among nursing personnel.	1	2	3	4	(7
6.	Improves communication between nursing and other health care providers.	1	2	3	4	(7
7.	Has decreased the fragmented documentation in the record.	1	2	3	4	(7
8.	Gives me a better "picture" of what happened to the patient.	1	2	3	4	(7
	**********					
9.	I did not document patient responses on the TDs.	1	2	3	4	(7
10.	I had minimal difficulty recording the patient's responses on the TDs.	1	2	3	4	(7
11.	The expanded use of the TDs (being able to document responses) is a concept which should be available to all nursing personnel worldwide.	1	2	3	4	(7
	**********					
"THE 'FOLDER' TYPE FORMAT . . ."						
12.	Is an improvement.	1	2	3	4	(8
13.	Should be kept even if it cannot be overprinted with orders.	1	2	3	4	(8
14.	Should have the patient identification block printed on all pages.	1	2	3	4	(8

		STRONGLY AGREE	AGREE	DISAGREE	STRONGLY DISAGREE	(N
15.	I like the sturdier paper on which the forms are printed.	1	2	3	4	(3
16.	Having separate pages for recurring, delayed, or prn action orders is helpful to me.	1	2	3	4	(3
17.	To my knowledge, there were no treatment or medication errors committed on my nursing unit which could be blamed on the new format of the TDs.	1	2	3	4	(3
18.	I would prefer to have the TDs in a single sheet format (like the "old" TDs) even knowing that I would have less room for documentation.	1	2	3	4	(3
19.	If a single sheet format were to be used, I would prefer a medium weight paper (less bulky than the tested paper).	1	2	3	4	(3
20.	All medication and non-medication forms should remain color-coded.	1	2	3	4	(3
21.	Yellow highlighter use should be reinstated to discontinue orders.	1	2	3	4	(3

SECTION F

INTEGRATED PROGRESS NOTES (SF 509)

		STRONGLY AGREE	AGREE	DISAGREE	STRONGLY DISAGREE	
"THE INTEGRATED PROGRESS NOTE . . ."						
1.	Improves communications concerning the patient among all health care providers.	1	2	3	4	(3

	STRONGLY AGREE	AGREE	DISAGREE	STRONGLY DISAGREE	(N
"THE INTEGRATED PROGRESS NOTE . . ."					
2. Has encouraged me to be more thorough in documentation.	1	2	3	4	(31)
3. Has encouraged me to be more concise in documentation.	1	2	3	4	(32)
4. Lessens fragmenting of information in the patient record.	1	2	3	4	(33)
5. Lessens the amount of information everyone must document.	1	2	3	4	(34)
6. Has saved me time in documenting (I feel I don't need to repeat information previously documented by another health care provider because it's all in the same place).	1	2	3	4	(35)
7. Encourages me to read other care providers' notes.	1	2	3	4	(36)
8. Should be used at all Army hospitals.	1	2	3	4	(37)
**********					
9. I had no difficulty distinguishing nursing notations from those of other disciplines.	1	2	3	4	(111)
10. Physicians on my nursing unit seemed to like having narrative nursing comments integrated with other patient care documentation.	1	2	3	4	(112)
11. Other health care professionals (e.g., physical therapist, dietitian, social worker, etc) seemed to like having narrative nursing comments integrated with other patient care documentation.	1	2	3	4	(113)

		STRONGLY AGREE	AGREE	DISAGREE	STRONGLY DISAGREE	N)
12.	Even though the guidelines said that all nursing personnel were authorized to chart on the progress notes, there were some exceptions to this policy on my nursing unit.	1	2	3	4	(1[illegible]

SECTION G

1. "IN MY OPINION, THE BOTTOM LINE TO EVERYTHING WE HAVE TESTED IS . . ." (circle ONE code)

   CODE # 1 = the system should be implemented exactly as tested.

   2 = we should go back to the "old" way and not use any of the tested elements. (1[illegible]

   3 = the system should be implemented with some modifications (please specify below).

   a. General Comments: (107-1[illegible]

   b. DA Form 3888-2 Test: (111-1[illegible]

   c. DA Form 3888-3 Test: (115-1[illegible]

   d. DA Form 3888-4 Test: (119-1[illegible]

   e. DA Form 3888-5 Test: (123-1[illegible]

   f. DA Form 4256-1 Test: (127-1[illegible]

g. DA Form 4256-2 Test: (131-134) (N.

h. DA Form 4677-1 Test: (135-138)

i. DA Form 4678-1 Test: (139-142)

j. Integrated Progress Notes: (143-146)

SECTION H

PROFESSIONAL DATA

This section concerns your professional and military background. To assist us in analysis, please answer each item.

1. "MY CURRENT MOS/DUTY DESCRIPTION IS . . ." (circle ONE code)

MILITARY/CIVILIAN

CODE # 08 = 91A/Nurse's Aide (147,148)
09 = 91B
10 = 91C/Practical Nurse
11 = 91F/Psychiatric Technicians
12 = Other (please specify)_____

2. Are you a Wardmaster? (circle ONE code)

CODE # 1 = YES (149)
2 = NO

3. "MY PRIMARY INPATIENT NURSING UNIT IS . . ." (circle ONE code)

CODE # 1 = Surgical Unit
2 = Psychiatric Unit
3 = Medical Unit
4 = Combined Medical/Surgical Unit (150)
5 = Pediatric Unit
6 = Critical Care Unit (all ICUs)
7 = L&D, NBN, Ante/Post-Partum Unit
8 = OR
9 = Other (please specify) _____

4. Number of years worked with Army inpatient medical records/documentation:
(one through six months, enter "00",
seven through 12 months, enter "01",
two years, enter "02", etc.)
(two digits)

(N
(154,155)

5. If there are any comments you would like to add about the information requested in this survey, the test forms, or documentation in general, please do so in the following space.

(156)
(157)
(158)
(159)
(160)

If more space is needed, please staple your responses to this questionnaire.

Thank you for your assistance!

Case # 3 (1-5)

DEPARTMENT OF THE ARMY
US ARMY HEALTH CARE STUDIES AND CLINICAL INVESTIGATION ACTIVITY
FORT SAM HOUSTON, TEXAS 78234

HSHN-H

23 June 1986

Dear Unit Clerk:

1. For the past several months you have been testing new forms and concepts of nursing documentation as part of the Clinical Nursing Records Study. The study was designed to develop a less cumbersome, more integrated and satisfactory alternative documentation system. Your enthusiasm and willingness to be an integral part of this effort has been greatly appreciated by the investigators.

2. We are now moving into the the evaluation phase, a key portion of which is to assess your satisfaction with the test forms and system of documentation. You are asked to respond to the following questions by comparing the items you "tested" with the manner in which you documented "before" the test forms. Recall that the test forms were a change in the way you "did business," and consequently, it took time to learn the new methods. As you answer, reflect on how you feel TODAY.

3. Your comments are crucial to the completion of this study. Changes to guidelines and forms design will be based upon your responses. If changes are adapted for worldwide use, your experience and comments will be invaluable to other personnel. Copies of the final report will be provided to test site chief nurses.

4. Thank you in advance for your assistance in this important study.

Sincerely,

Martha R. Bell

Martha R. Bell
LTC, ANC
Principal Investigator

CLINICAL NURSING RECORDS STUDY
SATISFACTION SURVEY

(W

********** ********** **********

It is neither the intent, nor will it be possible, to identify any one individual's responses in the final report. Do not place your name or any identifying information on the questionnaire. The control control number on the first page of the survey (upper right hand corner) is to enable a clerk to account for a returned copy. The principal investigator will receive your questionnaire after it has been returned to Fort Sam Houston and removed from the envelope. Completion of the questionnaire will be considered your consent to participate. Should you desire not to participate, please return the uncompleted questionnaire in the provided envelope to the project officer designated at your medical treatment facility.

********** ********** **********

Unless instructed to do otherwise in the following sections, please answer all questions by circling the numbered response that most closely reflects your opinion, or by writing in the information requested. If a question is unanswered, the investigator will assume you did not have enough experience with the tested documentation system to comment on that particular aspect. You will be provided the oppportunity to make written comments at the end of the questionnaire. Do not write entries by the questions. They may be overlooked during coding procedures.

SECTION A

"OVERALL, WHEN I COMPARE THE OLD SYSTEM OF DOCUMENTATION WITH THE ONE WE ARE TESTING, I FEEL THE TEST FORMS AND INTEGRATED PROGRESS NOTES . . ."

	STRONGLY AGREE	AGREE	DISAGREE	STRONGLY DISAGREE	DO NOT USE THIS SPACE
1. Help to avoid writing the same information several different places.	1	2	3	4	(7)
2. Are easier to use.	1	2	3	4	(11)
3. Should have been a more drastic change from the old system of documentation.	1	2	3	4	(12)
4. Are a definite improvement.	1	2	3	4	(13)
5. Reduce the amount of paperwork I have to do.	1	2	3	4	(14)

SECTION B

(W

NURSING HISTORY AND ASSESSMENT (DA Form 3888-2 Test)
NURSING HISTORY & ASSESSMENT CONTINUATION FORM (DA Form 3888-3 Test)
NURSING CARE PLAN (DA Form 3888-4 Test)

	STRONGLY AGREE	AGREE	DISAGREE	STRONGLY DISAGREE	
"ON MY NURSING UNIT . . ."					
1. The block for patient's personal articles and valuables is helpful.	1	2	3	4	(19)
2. Most nursing histories are done by non-RN/ANC personnel.	1	2	3	4	(20)
3. All nursing assessments are done by RNs and ANCs.	1	2	3	4	(21)
4. We often use the history and assessment continuation sheet.	1	2	3	4	(23)

****

SECTION C

NURSING DISCHARGE SUMMARY (DA Form 3888-5)

	STRONGLY AGREE	AGREE	DISAGREE	STRONGLY DISAGREE	
"OTHER THAN THE PATIENT IDENTIFICATION STAMP . . ."					
1. I have completed some portions of the nursing discharge summary for the nurses.	1	2	3	4	(32)
2. The entire nursing discharge summary is completed only by an RN/ANC on my nursing unit.	1	2	3	4	(33)

SECTION D

DOCTOR'S ORDERS MEDICATION/DOCTOR'S ORDERS NONMEDICATION
(DA Form 4256-1 Test/DA Form 4256-2 Test)

		STRONGLY AGREE	AGREE	DISAGREE	STRONGLY DISAGREE	
1.	We frequently use the buff copy of the order sheets on my nursing unit.	1	2	3	4	(40)
2.	I like not having to recopy some single action orders onto the Therapeutic Documentation Care Plans.	1	2	3	4	(41)
3.	Having doctor's orders separated onto medication and nonmedication sheets has caused minimal difficulty for me.	1	2	3	4	(60)
4.	Doctor's orders should remain separated on color-coded medication and nonmedication sheets.	1	2	3	4	(61)

****

"IF WE WENT BACK TO THE 'OLD' ORDER SHEETS (ALL ORDERS ON ONE SHEET) . . ."

5.	I would have no difficulty identifying completed single action orders.	1	2	3	4	(65)
6.	I would still want a column for single action orders to preclude my having to recopy them onto the Therapeutic Documentation Care Plans.	1	2	3	4	(66)

****

SECTION E

THERAPEUTIC DOCUMENTATION CARE PLANS, MEDICATION AND NONMEDICATION (DA Form 4677-1 Test; DA Form 4678-1 Test)

	STRONGLY AGREE	AGREE	DISAGREE	STRONGLY DISAGREE	
"THE 'FOLDER' TYPE FORMAT . . ."					
1. Is an improvement.	1	2	3	4	(81)
2. Should be kept even if it cannot be overprinted with orders.	1	2	3	4	(82)
3. Should have the patient identification block printed on all pages.	1	2	3	4	(83)
**********					
4. I like the sturdier paper on which the forms are printed.	1	2	3	4	(84)
5. Having separate pages for recurring, delayed, or prn action orders is helpful to me.	1	2	3	4	(85)
6. I would prefer to have the TDs in a single sheet format (like the "old" TDs) even knowing that I would have less room for writing.	1	2	3	4	(86)
7. If a single sheet format were to be used, I would prefer a medium weight paper (less bulky than the tested paper).	1	2	3	4	(87)
8. All medication and non-medication forms should remain color-coded.	1	2	3	4	(88)
9. Yellow highlighter use should be reinstated to discontinue orders.	1	2	3	4	(89)

NOTE: SECTION F NOT USED.

SECTION G

1. "IN MY OPINION, THE BOTTOM LINE TO EVERYTHING WE HAVE TESTED IS . . ." (circle ONE code)

Code # 1 = The system should be implemented exactly as tested.

2 = We should go back to the "old" way and not use any of the tested elements. (106)

3 = The system should be implemented with some modifications (please specify below).

a. General Comments: (107-110)

b. DA Form 3888-2 Test: (111-114)

c. DA Form 3888-3 Test: (115-118)

d. DA Form 3888-4 Test: (119-122)

e. DA Form 3888-5 Test: (123-126)

f. DA Form 4256-1 Test: (127-130)

g. DA Form 4256-2 Test: (131-134)

h. DA Form 4677-1 Test: (135-138)

i. DA Form 4678-1 Test: (139-142)

j. Integrated Progress Notes: (143-146)

SECTION H

DEMOGRAPHIC DATA

To assist us in analysis, please answer each item.

1. "MY PRIMARY AREA OF ASSIGNMENT IS ON A . . ."
   (circle ONE code)

   CODE # 1 = Surgical Unit
   2 = Psychiatric Unit
   3 = Medical Unit
   4 = Combined Medical/Surgical Unit
   5 = Pediatric Unit
   6 = Critical Care Unit (all ICUs)
   7 = L&D, NBN, Ante/Post-Partum Unit
   9 = Other (please specify) _____

2. Number of years worked with Army inpatient medical records/documentation:
   (one through six months, enter code "00",
   seven through 12 months, enter "01"
   two years, enter "02", etc.) ____ (two digits)

3. If there are any comments you would like to add about the information requested in this survey, the test forms, or documentation in general, please do so in the following space.

Thank you for your assistance!

Case # 4 (1-5)

DEPARTMENT OF THE ARMY
US ARMY HEALTH CARE STUDIES AND CLINICAL INVESTIGATION ACTIVITY
FORT SAM HOUSTON, TEXAS 78234

HSHN-Z

23 June 1986

Dear Colleague:

1. As health care providers, we obviously try to provide the highest quality of patient care. At the same time, the requirements to document that care always seem to be increasing. Our nurse colleagues assume a large responsibility in meeting these documentation requirements. They, like you, are very concerned about the amount of time these documentation efforts take; time taken away from direct patient care. Therefore, under the Army Study Program, this command has been conducting a study to develop a more integrated and satisfactory alternative documentation system, while meeting recognized Army and JCAH standards. Portions of the Clinical Nursing Records Study have directly impacted on the way you "do business" by testing new order forms and integrated concepts of documentation.

2. The study is now moving into the evaluation phase, an important part of which is assessing satisfaction with the tested changes. To assist the investigators in their efforts, please take a few minutes to answer the attached questions. You are asked to respond by comparing the items you "tested" with the manner in which you previously documented patient care. The questionnaire will take approximately 10 minutes to complete.

3. Your comments are crucial to the completion of this study. Changes to quidelines and forms design will be made based upon your responses. Thank you for your assistance. If you should have any questions, please contact your local project officer through the Department of Nursing.

LARRY E. BECKER
LTC, MC
Commanding

CLINICAL NURSING RECORDS STUDY

PROFESSIONAL STAFF SURVEY

****

It is neither the intent, nor will it be possible, to identify any one individual's responses in the final report. Do not place your name or any identifying information on the questionnaire. The control number on the first page of the survey (upper right hand corner) is to enable a clerk to account for a returned copy. The principal investigator will receive your questionnaire after it has been returned to Fort Sam Houston and removed from the envelope. Completion of the questionnaire will be considered your consent to participate. Should you desire not to participate, please return the uncompleted questionnaire in the provided envelope to the project officer designated at your medical treatment facility.

********** ********** **********

Unless instructed to do otherwise in the following sections, please answer all questions by circling the numbered response that most closely reflects your opinion, or by writing in the information requested. If a question is unanswered, the investigator will assume you did not have enough experience with the tested documentation system to comment on that particular aspect.

SECTION 1 (VAR CODE X)

PROFESSIONAL STAFF USE OF NURSING DOCUMENTATION FORMS

DURING THE TEST PERIOD, nursing care has been documented on several different forms. Among these are the:

Nursing History and Assessment (DA Form 3888-2 TEST)
Nursing Care Plan (DA Form 3888-4 TEST)
Nursing Discharge Summary (DA Form 3888-5 TEST)
Therapeutic Documentation Care Plan, Nonmedication (DA Form 4677-1 TEST); "green sheet"
Therapeutic Documentation Care Plan, Medication (DA Form 4678-1 TEST); "white sheet"
Progress Notes (SF 509)
TPR Graphic (SF 511)

1. **DURING THE TEST PERIOD,** HOW OFTEN DID YOU USE THE FOLLOWING FORMS TO LEARN ABOUT NURSING ACTIVITIES AND THE PATIENT'S CONDITION?

	FOR EVERY PATIENT	FOR MOST PATIENTS	RARELY	NEVER	DO NOT USE THIS SPACE
a. Nursing History and Assessment	1	2	3	4	(42)
b. Nursing Care Plan	1	2	3	4	(43)
c. Nursing Discharge Summary	1	2	3	4	(44)
d. Therapeutic Documentation Care Plan, Nonmedication ("green sheet")	1	2	3	4	(45)
e. Therapeutic Documentation Care Plan, Medication ("white sheet")	1	2	3	4	(46)
f. TPR Graphic	1	2	3	4	(47)
g. Progress Notes	1	2	3	4	(48)
h. Other (please specify) _____ _____	1	2	3	4	(49)

2. **DURING THE TEST PERIOD,** THE FORM I USED MOST OFTEN TO REVIEW NURSING CARE WAS:

_____ (50)

PRIOR TO THE TEST PERIOD, all the previously listed forms were used to document nursing care, with the exception of the Progress Notes (SF 509). Narrative nursing notations were recorded on the "Nursing Notes" form (SF 510).

3. **PRIOR TO THE TEST PERIOD,** HOW OFTEN HAD YOU USED THE FOLLOWING FORMS TO LEARN ABOUT NURSING ACTIVITIES AND THE PATIENT'S CONDITION?

	FOR EVERY PATIENT	FOR MOST PATIENTS	RARELY	NEVER	
a. Nursing History and Assessment	1	2	3	4	(51)
b. Nursing Care Plan	1	2	3	4	(52)
c. Nursing Discharge Summary	1	2	3	4	(53)
d. Therapeutic Documentation Care Plan, Nonmedication "green sheet"	1	2	3	4	(54)
e. Therapeutic Documentation Care Plan, Medication "white sheet"	1	2	3	4	(55)
f. TPR Graphic	1	2	3	4	(56)
g. Nursing Notes	1	2	3	4	(57)
h. Other (please specify)	1	2	3	4	(58)

_____

_____

4. **PRIOR TO THE TEST PERIOD,** THE FORM I USED MOST OFTEN TO REVIEW NURSING CARE WAS:

_____ (59)

SECTION 2 (VAR CODE D)

DOCTOR'S ORDERS MEDICATION/DOCTOR'S ORDERS NONMEDICATION (DA Form 4256-1 TEST; DA Form 4256-2 TEST)

Two separate, but color-coded order sheets were designed to allow easy access to drug orders, without reviewing all other orders to provide prompt identification of "STAT" doses, and to improve tracking of drug/drug and drug/food interactions. In addition, the test sheets provided a column for nurses to indicate completed single action orders without recopying the order onto another form. Please complete the following, reflecting your experience with these forms.

	STRONGLY AGREE	AGREE	DISAGREE	STRONGLY DISAGREE	
1. Having two separate order sheets caused minimal difficulties for me.	1	2	3	4	(60)
2. Orders should continue to remain separated on color coded medication and nonmedication sheets.	1	2	3	4	(61)
3. Please use the following space to make additional comments as necessary:					(62)

DOCTOR'S ORDERS MEDICATION/DOCTOR'S ORDERS NONMEDICATION (continued)
(DA Form 4256-1 TEST; DA Form 4256-2 TEST)

****

4. "**PRIOR TO THE TEST PERIOD,** if unfamiliar with a patient, I most often determined current medication(s) by . . ." (circle ONE code)

CODE # 1 = reviewing all the doctor's orders.

2 = reviewing the Therapeutic Documentation CarePlan, Medication ("white sheet").

3 = asking the nurse. (63)

4 = other (please specify) _____.

****

5. "**DURING THE TEST PERIOD,** after the separation of the orders, if unfamiliar with a patient, I most often determined current medication(s) by . . ." (circle ONE code)

CODE # 1 = reviewing the medication doctor's order sheet.

2 = reviewing the Therapeutic Documentation Care Plan, Medication ("white sheet").

3 = asking the nurse. (64)

4 = other (please specify) _____.

****

SECTION 3 (VAR CODE F

INTEGRATED PROGRESS NOTES (SF 509)

The term "integrated progress notes" refers to the concept of all disciplines, including nursing, documenting the patient's progress in one section of the medical record, rather than having a separate area for narrative nursing comments.

	STRONGLY AGREE	AGREE	DISAGREE	STRONGLY DISAGREE	
"THE INTEGRATED PROGRESS NOTE . . ."					
1. Improves communications concerning the patient among all health care providers.	1	2	3	4	(90)
2. Lessens fragmented information in the patient record.	1	2	3	4	(93)
3. Lessens the amount of information everyone must document.	1	2	3	4	(94)
4. Encourages me to read narrative nursing notes more than I did in the past.	1	2	3	4	(95)
5. Makes it easier to determine what is happening with my patient.	1	2	3	4	(96)
6. Should be used at all Army hospitals.	1	2	3	4	(99)
**********					
7. I had little difficulty identifying who wrote previous narrative notations.	1	2	3	4	(100)
8. I had little difficulty identifying nursing notations.	1	2	3	4	(101)
9. I had little difficulty locating my previous narrative notations.	1	2	3	4	(102)

SECTION 4 (VAR CODE H

PROFESSIONAL DATA

To assist in analysis, please answer each item.

1. "MY CORPS AFFILIATION IS . . ." (circle ONE code)

   1 = AMSC/civilian counterpart
   2 = DC/civilian counterpart
   3 = MC/civilian counterpart
   4 = MSC/civilian counterpart
   5 = WO/PA
   6 = Other (specify) _____ (153)

2. Number of years worked with Army inpatient medical records/documentation. (one through six months, enter "00", seven through 12 months, enter "01", two years, enter "02", etc.) (two digits) (154,155)

3. If there are any comments you would like to add about the information requested in this survey, the test forms, or documentation in general, please do so in the following space.

Thank you for your assistance!

(156)
(157)
(158)
(159)
(160)

INSTRUCTIONS FOR DISTRIBUTION AND RETURN OF CLINICAL NURSING RECORDS STUDY QUESTIONNAIRES:

Cases containing the serially numbered CNR Study questionnaires and envelopes (with corresponding numbers) for distribution at your facility were shipped to all CNR project officers on 16 July. The following directions are mailed to you to allow you time to set up your distribution and retrieval system. Time constraints placed on this activity allow minimal time for distribution activities, so you will need to be organized and ready to hand out questionnaires when they arrive.

Enough copies have been provided for each participant plus some extras for those who might misplace theirs, or in case the original estimate was off. The first digit of the Case number in the upper right hand corner of the cover letter and its envelope signifies the TYPE CODE:

1 = Registered Nurses (civilian, military, contract)
2 = Paraprofessional (civilian, military)
3 = Ward Clerks
4 = Other Professional Staff (AMSC, MC, MSC and civilian counterparts

The second digit of the Case number is the test SITE CODE.

The last three digits are the individual case number, unique to each participant. The box with the questionnaires also contains a piece of paper on which is listed the beginning and ending stamped sequence number for each questionnaire type. IF YOU NEED TO USE ANY OF THE UNNUMBERED QUESTIONNAIRES, SELECT THE CORRECT TYPE (1, 2, 3, or 4), SITE CODE, AND NUMBER FOLLOWING IN SEQUENCE (5 digits in all).

If necessary, select someone who can assist with the logistics of distribution and return. However, you retain ultimate responsibility for the operation.

****

DISTRIBUTION

1. Write down all the instructions you and your assistant will be giving to each individual to insure consistency as you distribute questionnaires (a sample list is included at the end of this paper).

2. Draw up rosters for the four groups of participants, checking names off as you have handed out envelopes containing the questionnaires. Recommend that all questionnaires be handed to participants by either yourself, or your designated assistant. Items placed in mailboxes have a tendency to be lost. Remember, you are ultimately responsible for monitoring the return of questionnaires from participants; the longer it takes for participants to respond, the less chance you have of getting them back. (One

possibility is to distribute the questionnaires at the change of shift with instructions that you will collect them at the end of the shift.) A timely response is imperative. If some personnel are unavailable during the days you have to distribute and collect the questionnaires, but will be back prior to the date you must mail responses to Fort Sam Houston, they can be given a questionnaire, with emphasis on prompt return. Otherwise, begin your distribution on or about 22/23 July, one questionnaire to each participant, requesting return within 2-3 days (NLT 28 July).

4. Obtain the support of all Department Chiefs. Ask that they strongly and vocally solicit each individual's participation. Meetings such as professional staff conferences, end of shift reports, etc. could be used as a forum to hand out questionnaires and encourage participation.

RETURN OF QUESTIONNAIRES TO PROJECT OFFICER

1. Instruct all participants to return questionnaires in their coded envelopes, sealing them prior to return. A mechanism must be set up to allow you to identify those who have not returned their questionnaires by your deadline while maintaining the anonymity of the respondents who have returned envelopes. Some possible ways are a detachable name slip that respondents can drop in a separate container when they return the questionnaire, or perhaps a list available for them to check off their name.

2. You can decide where and how you would like the questionnaires returned to you. If you are fairly "mobile" you might want to have collection points on each unit. Several points will probably be needed, particularly in the larger facilities. Instruct participants on the return system set up for each of them.

3. Make your best effort at getting all questionnaires back. While there are instructions for completing and returning questionnaires contained in each participant's booklet, instruct individuals who opt not to participate to return the questionnaire to you in the sealed coded envelope. You will not have access to the questionnaire once it is sealed in its envelope. We at FSH will not be able to identify any one participant at any test site.

RETURN OF QUESTIONNAIRES TO HEALTH CARE STUDIES

1. It is very important that you report to us the exact number of each TYPE of questionnaire distributed; the return rate can be calculated from the returned envelopes. Pass that information along via letter to LTC Bell with the returned surveys NLT 1 August.

2. All questionnaires need to be returned to Health Care Studies NLT 1 August. Mailing labels are attached for your convenience. On/about Monday, 28 July, mail all questionnaires returned to you up to that date.

At that time we also suggest you issue some sort of plea for nonrespondents to submit their questionnaires.

3. Mail the balance of the responses, and any unused questionnaires, NLT 31 July. Again, time constraints for coding purposes, etc, will not afford us additional time to wait on late submissions.

SUGGESTED PARTICIPANT INSTRUCTION LIST

1. 'This is the satisfaction questionnaire for the test forms study' (or words to that effect)

2. 'Should take you about _____ to complete.'

RN: approx 30 minutes
Para: approx 30 minutes
WC: approx 15 minutes
Other Prof Staff: approx 10 minutes

3. 'The directions for completing the survey are in the booklet.'

4. Repeat the retrieval mechanism you have set up at your hospital. Emphasize the DEADLINE.

5. 'Seal the envelope before returning to project officer.'

6. 'Those choosing not to participate...return blank questionnaire in sealed envelope.'

7. If the need arises, where and how they can contact the project officer/assistant.

8. 'Results of the study will be disseminated to all facilities.' Thank them for their support and assistance.

****

Everyone who has worked on this project is committed to its importance, as are the leaders of the Army Nurse Corps. Unless participants are willing to share their perceptions and experiences with the test forms, even changes that are possible may not be made.

We are also highly committed to dissemination of the study findings. A copy of the summary data will be provided to each of your facilities at the completion of the project.

If there are any questions please contact either:

LTC Martha Bell AV 471-4880/5880 (Optimis Account 'MBELL')
Pat Twist AV 471-5671/3331

GOOD LUCK!

APPENDIX I

CNR Study Test Site Personnel Survey Responses

All Sites

Table 1

CLINICAL NURSING RECORDS STUDY

TYPE OF RESPONDENT

VALUE LABEL	VALUE	FREQUENCY	PERCENT	VALID PERCENT	CUM PERCENT
RNS	1	316	37.4	37.4	37.4
PARA	2	266	31.4	31.4	68.8
WARD CLERK	3	35	4.1	4.1	72.9
PROFESSIONAL	4	229	27.1	27.1	100.0
	TOTAL	846	100.0	100.0	

VALID CASES 846 MISSING CASES 0

Table 2

CLINICAL NURSING RECORDS STUDY

TEST SITES

VALUE LABEL	VALUE	FREQUENCY	PERCENT	VALID PERCENT	CUM PERCENT
	0	1	.1	.1	.1
CAMPBELL	1	133	15.7	15.7	15.8
FITZIMONS	2	398	47.0	47.0	62.9
JACKSON	3	170	20.1	20.1	83.0
POLK	4	144	17.0	17.0	100.0
	TOTAL	846	100.0	100.0	

VALID CASES 846 MISSING CASES 0

Table 3

CLINICAL NURSING RECORDS STUDY

"COMPARED TO THE OLD SYSTEM, I FEEL THE TEST FORMS SAVE NURSING DOCUMENTATION TIME" BY TYPE OF PROVIDER

A1	COUNT / TYPE	IRNS (1I)	PARA (2I)	ROW TOTAL
1	STRONGLY AGREE	151	97	248
				44.5
2	AGREE	123	123	246
				44.2
3	DISAGREE	20	28	48
				8.6
4	STRONGLY DISAGREE	10	5	15
				2.7
	COLUMN TOTAL	304	253	557
		54.6	45.4	100.0

NUMBER OF MISSING OBSERVATIONS = 289

Table 4

CLINICAL NURSING RECORDS STUDY

"COMPARED TO THE OLD SYSTEM, I FEEL THE TEST FORMS HELP AVOID WRITING SAME INFORMATION SEVERAL PLACES" BY TYPE OF PROVIDER

A2	COUNT / TYPE	RNS (1)	PARA (2)	WARD CLERK (3)	ROW TOTAL
1 STRONGLY AGREE		147	106	11	264
					44.9
2 AGREE		123	119	16	256
					43.9
3 DISAGREE		17	25	5	47
					8.0
4 STRONGLY DISAGREE		15	3	1	19
					3.2
	COLUMN TOTAL	302	253	33	588
		51.4	43.0	5.6	100.0

NUMBER OF MISSING OBSERVATIONS = 251

Table 5

CLINICAL NURSING RECORDS STUDY

"COMPARED TO THE OLD SYSTEM, I FEEL THE TEST FORMS IMPROVE COMMUNICATIONS ABOUT THE PATIENT AMONG NURSING PERSONNEL" BY TYPE OF PROVIDER

A3	COUNT / TYPE	IRNS (1)	PARA (2)	ROW TOTAL
1	STRONGLY AGREE	71	55	126
				22.7
2	AGREE	168	146	314
				56.5
3	DISAGREE	53	43	96
				17.3
4	STRONGLY DISAGRE	12	8	20
				3.6
	COLUMN TOTAL	304	252	556
		54.7	45.3	100.0

NUMBER OF MISSING OBSERVATIONS = 290

Table 6

CLINICAL NURSING RECORDS STUDY

"COMPARED TO THE OLD SYSTEM, I FEEL THE TEST FORMS IMPROVE COMMUNICATIONS ABOUT THE PATIENT BETWEEN NURSING AND OTHER HEALTH CARE PROFESSIONALS" BY TYPE OF PROVIDER

A4	COUNT / TYPE	1 RNS	2 PARA	ROW TOTAL
1 STRONGLY AGREE		79	59	138
		14.2	23.3	24.8
2 AGREE		155	139	294
		27.9	54.9	52.8
3 DISAGREE		55	50	105
		9.9	19.8	18.9
4 STRONGLY DISAGREE		15	5	20
		2.7	2.0	3.6
COLUMN TOTAL		304	253	557
		54.6	45.4	100.0

NUMBER OF MISSING OBSERVATIONS = 289

Table 7

CLINICAL NURSING RECORDS STUDY

"COMPARED TO THE OLD SYSTEM, I FEEL THE TEST FORMS ENCOURAGE ME TO USE THE NURSING PROCESS"

BY TYPE OF PROVIDER

A5	TYPE COUNT IRNS	ROW TOTAL
1 STRONGLY AGREE	66	66 22.0
2 AGREE	154	154 51.3
3 DISAGREE	71	71 23.7
4 STRONGLY DISAGRE	9	9 3.0
COLUMN TOTAL	300 100.0	300 100.0

NUMBER OF MISSING OBSERVATIONS = 546

Table 8

CLINICAL NURSING RECORDS STUDY

"COMPARED TO THE OLD SYSTEM, I FEEL THE TEST FORMS ARE EASIER TO USE" BY TYPE OF PROVIDER

AC	COUNT	TYPE: RNS (1)	PAPA (2)	WARD CLERK (3)	ROW TOTAL
STRONGLY AGREE	1	106	88	8	202
					34.2
AGREE	2	156	137	22	315
					53.3
DISAGREE	3	55	26	2	63
					10.7
STRONGLY DISAGREE	4	7	1	3	11
					1.9
	COLUMN TOTAL	306	252	33	591
		51.8	42.6	5.6	100.0

NUMBER OF MISSING OBSERVATIONS = 255

Table 9

CLINICAL NURSING RECORDS STUDY

"COMPARED TO THE OLD SYSTEM, I FEEL THE TEST FORMS SHOULD HAVE BEEN A MORE DRASTIC CHANGE" BY TYPE OF PROVIDER

A7	COUNT	TYPE IRNS 1	PARA 2	WARD CLERK 3	ROW TOTAL
1 STRONGLY AGREE		19	18	2	39
					6.9
2 AGREE		57	70	10	137
					24.2
3 DISAGREE		177	141	19	337
					59.5
4 STRONGLY DISAGREE		38	14	1	53
					9.4
COLUMN TOTAL		291	243	32	566
		51.4	42.9	5.7	100.0

NUMBER OF MISSING OBSERVATIONS = 280

Table 10

CLINICAL NURSING RECORDS STUDY

"COMPARED TO THE OLD SYSTEM, I FEEL THE TEST FORMS ARE A DEFINITE IMPROVEMENT" BY TYPE OF PROVIDER

AE	TYPE: RNS (1)	PAPA (2)	WARD CLERK (3)	ROW TOTAL
1 STRONGLY AGREE	103	69	10	162
				30.8
2 AGREE	166	154	18	338
				57.2
3 DISAGREE	27	28	6	61
				10.3
4 STRONGLY DISAGREE	8	2		10
				1.7
COLUMN TOTAL	304	253	34	591
	51.4	42.8	5.8	100.0

NUMBER OF MISSING OBSERVATIONS = 255

Table 11

CLINICAL NURSING RECORDS STUDY

"COMPARED TO THE OLD SYSTEM, I FEEL THE TEST FORMS PROVIDE ME A BETTER PICTURE OF WHAT IS HAPPENING TO THE PATIENT" BY TYPE OF PROVIDER

A9	COUNT	TYPE: IRNS (1)	TYPE: PARA (2)	ROW TOTAL
1 STRONGLY AGREE	1	58	51	109
				19.7
2 AGREE	2	173	154	327
				59.0
3 DISAGREE	3	65	44	109
				19.7
4 STRONGLY DISAGREE	4	6	3	9
				1.6
	COLUMN TOTAL	302	252	554
		54.5	45.5	100.0

NUMBER OF MISSING OBSERVATIONS = 292

Table 12

CLINICAL NURSING RECORDS STUDY

"COMPARED TO THE OLD SYSTEM, I FEEL THE TEST FORMS REDUCE THE AMOUNT OF PAPERWORK I HAVE TO DO"

BY TYPE OF PROVIDER

A1C	TYPE: 1 RNS	2 PARA	3 WARD CLERK	ROW TOTAL
1 STRONGLY AGREE	112	91	10	213
				36.2
2 AGREE	122	99	11	232
				39.5
3 DISAGREE	51	53	10	114
				19.4
4 STRONGLY DISAGREE	19	8	2	29
				4.9
COLUMN TOTAL	304	251	33	588
	51.7	42.7	5.6	100.0

NUMBER OF MISSING OBSERVATIONS = 258

Table 13

CLINICAL NURSING RECORDS STUDY

"COMPARED TO THE OLD SYSTEM, I FEEL THE TEST FORMS HAVE IMPROVED THE QUALITY OF DOCUMENTATION ON MY NURSING UNIT" BY TYPE OF PROVIDER

	TYPE		
COUNT	IRNS	PARA	ROW TOTAL
	1	2	
All			
1 STRONGLY AGREE	62	57	119 21.8
2 AGREE	149	135	284 51.9
3 DISAGREE	75	47	122 22.3
4 STRONGLY DISAGREE	11	11	22 4.0
COLUMN TOTAL	297 54.3	250 45.7	547 100.0

NUMBER OF MISSING OBSERVATIONS = 299

Table 14

CLINICAL NURSING RECORDS STUDY

"THE NUMBER OF NURSING HISTORY QUESTIONS IS ADEQUATE"

BY TYPE OF PROVIDER

E1	COUNT	TYPE 1 RNS	TYPE 2 PARA	ROW TOTAL
1 STRONGLY AGREE		72	40	112
				21.5
2 AGREE		159	164	323
				62.1
3 DISAGREE		45	34	79
				15.2
4 STRONGLY DISAGRE		5	1	6
				1.2
	COLUMN TOTAL	281	239	520
		54.0	46.0	100.0

NUMBER OF MISSING OBSERVATIONS = 326

Table 15

CLINICAL NURSING RECORDS STUDY

"THE CONTENT OF THE NURSING HISTORY QUESTIONS IS AS THOROUGH AS I NEED THEM TO BE" BY TYPE OF PROVIDER

B2	COUNT	TYPE 1 RNS	TYPE 2 PAFA	ROW TOTAL
1 STRONGLY AGREE		57	31	88
				17.0
2 AGREE		156	158	314
				60.6
3 DISAGREE		62	44	106
				20.5
4 STRONGLY DISAGREE		7	3	10
				1.9
COLUMN TOTAL		282	236	518
		54.4	45.6	100.0

NUMBER OF MISSING OBSERVATIONS = 326

Table 16

CLINICAL NURSING RECORDS STUDY

"ON MY NURSING UNIT THE BLOCK FOR PATIENT'S PERSONAL ARTICLES AND VALUABLES IS HELPFUL"

BY TYPE OF PROVIDER

E3	TYPE COUNT I	RNS I I 1I	PARA 2I	WARD CLERK 3I	ROW TOTAL
1 STRONGLY AGREE		44	44	6	94 17.1
2 AGREE		141	136	15	294 53.5
3 DISAGREE		74	50	7	131 23.8
4 STRONGLY DISAGREE		20	9	2	31 5.6
COLUMN TOTAL		279 50.7	241 43.8	30 5.5	550 100.0

NUMBER OF MISSING OBSERVATIONS = 296

Table 17

CLINICAL NURSING RECORDS STUDY

"ON MY NURSING UNIT MOST NURSING HISTORIES ARE DONE BY NON-RN/ANC PERSONNEL."

E4	COUNT / TYPE	RNS 1	PARA 2	WARD CLERK 3	ROW TOTAL
1 STRONGLY AGREE		38	43	9	90
					15.9
2 AGREE		77	80	12	169
					29.9
3 DISAGREE		136	101	7	214
					37.9
4 STRONGLY DISAGRE		68	24		92
					16.3
	COLUMN TOTAL	289	248	28	565
		51.2	43.9	5.0	100.0

NUMBER OF MISSING OBSERVATIONS = 281

Table 18

CLINICAL NURSING RECORDS STUDY

"ON MY NURSING UNIT ALL NURSING ASSESSMENTS ARE DONE BY RNs AND ANCs" BY TYPE OF PROVIDER

E5	TYPE COUNT / ROW PCT	1 RNS	2 PAPA	3 WARD CLERK	ROW TOTAL
1 STRONGLY AGREE		176	78	12	266
					45.5
2 AGREE		92	69	13	184
					31.8
3 DISAGREE		39	75	4	118
					20.4
4 STRONGLY DISAGREE		4	11	1	16
					2.8
	COLUMN TOTAL	295	253	30	578
		51.0	43.8	5.2	100.0

NUMBER OF MISSING OBSERVATIONS = 268

Table 19

CLINICAL NURSING RECORDS STUDY

"ON MY NURSING UNIT AN OVERPRINT IS USED FOR THE ASSESSMENT" BY TYPE OF PROVIDER

BY	COUNT	TYPE I IRNS I I	ROW TOTAL
		II	
	1	59	59
STRONGLY AGREE			21.0
	2	76	76
AGREE			27.0
	3	94	94
DISAGREE			33.5
	4	52	52
STRONGLY DISAGRE			18.5
	COLUM. TOTAL	281 100.0	281 100.0

NUMBER OF MISSING OBSERVATIONS = 565

Table 20

CLINICAL NURSING RECORDS STUDY

"ON MY NURSING UNIT WE OFTEN USE THE HISTORY AND ASSESSMENT CONTINUATION SHEET"

BY TYPE OF PROVIDER

B7	TYPE			
COUNT	RNS	PARA	WARD CLERK	ROW TOTAL
	1	2	3	
1 STRONGLY AGREE	37	24	3	64
				11.7
2 AGREE	56	122	9	187
				34.1
3 DISAGREE	122	78	11	211
				38.4
4 STRONGLY DISAGREE	69	10	8	87
				15.8
COLUMN TOTAL	284	234	31	549
	51.7	42.6	5.6	100.0

NUMBER OF MISSING OBSERVATIONS = 297

Table 21

CLINIC NURSING RECORDS STUDY

"OVERPRINTING THE ASSESSMENT CATEGORIES FROM THE STANDARDS OF NURSING PRACTICE (DA PAM 40-5) IS HELPFUL TO ME" BY TYPE OF PROVIDER

BE	COUNT	TYPE I ITEMS I I I II	ROW TOTAL
STRONGLY AGREE	1	90	90 35.4
AGREE	2	124	124 48.8
DISAGREE	3	23	23 9.1
STRONGLY DISAGREE	4	17	17 6.7
	COLUMN TOTAL	254 100.0	254 100.0

NUMBER OF MISSING OBSERVATIONS = 592

Table 22

CLINIC NURSING RECORDS STUDY

"OVERPRINTING THE ASSESSMENT CATEGORIES FROM THE STANDARDS OF NURSING PRACTICE (DA PAM 40-5) HAS INCREASED MY USE OF THE CATEGORIES" BY TYPE OF PROVIDER

		TYPE	
	COUNT	I	
		IRNS	ROW
		I	TOTAL
		I II	
BC	--------+--------+		
	1	I 71 I	71
STRONGLY AGREE		I I	28.4
		+--------+	
	2	I 122 I	122
AGREE		I I	48.8
		+--------+	
	3	I 41 I	41
DISAGREE		I I	16.4
		+--------+	
	4	I 16 I	16
STRONGLY DISAGREE		I I	6.4
		+--------+	
	COLUMN	250	250
	TOTAL	100.0	100.0

NUMBER OF MISSING OBSERVATIONS = 596

Table 23

CLINIC NURSING RECORDS STUDY

"OVERPRINTING THE ASSESSMENT CATEGORIES FROM THE STANDARDS OF NURSING PRACTICE (DA PAM 40-5) SHOULD BE CONTINUED" BY TYPE OF PROVIDER

	TYPE	
COUNT	IRNS	ROW TOTAL
BIC	11	
1 STRONGLY AGREE	94	94 38.1
2 AGREE	122	122 49.4
3 DISAGREE	19	19 7.7
4 STRONGLY DISAGREE	12	12 4.9
COLUMN TOTAL	247 100.0	247 100.0

NUMBER OF MISSING OBSERVATIONS = 599

Table 24

CLINICAL NURSING RECORDS STUDY

"I LIKE THE IDEA OF THE NURSING HISTORY AND ASSESSMENT, IF COMPLETED ON ADMISSION, SERVING AS THE ADMISSION NURSING NOTE" BY TYPE OF PROVIDER

B11	COUNT	TYPE RNS	ROW TOTAL
		11	
STRONGLY AGREE	1	210	210 71.9
AGREE	2	73	73 25.0
DISAGREE	3	6	6 2.1
STRONGLY DISAGREE	4	3	3 1.0
	COLUMN TOTAL	292 100.0	292 100.0

NUMBER OF MISSING OBSERVATIONS = 554

Table 25

CLINICAL NURSING RECORDS STUDY

"OVERPRINTING THE NURSING DIAGNOSES ONTO THE CARE PLAN IS HELPFUL TO ME" BY TYPE OF PROVIDER

B12 / COUNT	TYPE: IRNS (11)	ROW TOTAL
1 STRONGLY AGREE	131	131
		47.3
2 AGREE	114	114
		41.2
3 DISAGREE	23	23
		8.3
4 STRONGLY DISAGREE	9	9
		3.2
COLUMN TOTAL	277	277
	100.0	100.0

NUMBER OF MISSING OBSERVATIONS = 569

Table 26

CLINICAL NURSING RECORDS STUDY

"OVERPRINTING THE NURSING DIAGNOSES ONTO THE CARE PLAN HAS INCREASED MY USE OF THE DIAGNOSES" BY TYPE OF PROVIDER

P13	COUNT	TYPE IRNS 1	ROW TOTAL
STRONGLY AGREE	1	113	113 41.9
AGREE	2	115	115 42.6
DISAGREE	3	33	33 12.2
STRONGLY DISAGREE	4	9	9 3.3
	COLUMN TOTAL	270 100.0	270 100.0

NUMBER OF MISSING OBSERVATIONS = 576

Table 27

CLINICAL NURSING RECORDS STUDY

"OVERPRINTING THE NURSING DIAGNOSES ONTO THE CARE PLAN SHOULD BE CONTINUED" BY TYPE OF PROVIDER

B14	COUNT	TYPE I IRMS I II	ROW TOTAL
STRONGLY AGREE	1	132	132
			47.7
AGREE	2	117	117
			42.2
DISAGREE	3	17	17
			6.1
STRONGLY DISAGREE	4	11	11
			4.0
	COLUMN TOTAL	277 100.0	277 100.0

NUMBER OF MISSING OBSERVATIONS = 569

Table 28

CLINICAL NURSING RECORDS STUDY

"I READ THE NURSING CARE PLAN TO LEARN THE OVERALL GOALS FOR THE PATIENT" BY TYPE OF PROVIDER

	TYPE		
COUNT	PARA		ROW TOTAL
	21		
E15			
1 STRONGLY AGREE	52		52
2 AGREE	165		165
3 DISAGREE	27		27
4 STRONGLY DISAGREE	6		6
COLUMN TOTAL	250		250

NUMBER OF MISSING OBSERVATIONS = 590

Table 29

CLINICAL NURSING RECORDS STUDY

"OTHER THAN THE PATIENT IDENTIFICATION STAMP, I HAVE COMPLETED SOME PORTIONS OF THE NURSING DISCHARGE SUMMARY FOR THE NURSES" BY TYPE OF PROVIDER

C1	COUNT	TYPE 2 PARA	3 WARD CLERK	ROW TOTAL
1 STRONGLY AGREE		42	4	46
				16.8
2 AGREE		92	10	102
				37.4
3 DISAGREE		87	11	98
				35.9
4 STRONGLY DISAGREE		21	6	27
				9.9
	COLUMN TOTAL	242	31	273
		88.6	11.4	100.0

NUMBER OF MISSING OBSERVATIONS = 573

Table 30

CLINICAL NURSING RECORDS STUDY

"OTHER THAN THE PATIENT IDENTIFICATION STAMP, THE ENTIRE NURSING DISCHARGE SUMMARY IS COMPLETED ONLY BY AN RN/ANC ON MY NURSING UNIT" BY TYPE OF PROVIDER

C2	COUNT	TYPE PARA	WARD CLERK	ROW TOTAL
1 STRONGLY AGREE		44	10	54
				19.3
2 AGREE		87	10	97
				34.6
3 DISAGREE		91	9	100
				35.7
4 STRONGLY DISAGREE		28	1	29
				10.4
COLUMN TOTAL		250	30	280
		89.3	10.7	100.0

NUMBER OF MISSING OBSERVATIONS = 566

Table 31

CLINICAL NURSING RECORDS STUDY

"NURSING DISCHARGE SUMMARY (DA FORM 3888-5 TEST) - ELEMENTS ON THE FORM ARE THOSE I WOULD INCLUDE IN A DISCHARGE NURSING NOTE" BY TYPE OF PROVIDER

C3	TYPE		
COUNT	IRNS		ROW TOTAL
	I	II	
1 STRONGLY AGREE	105		105
			38.7
2 AGREE	148		148
			54.6
3 DISAGREE	12		12
			4.4
4 STRONGLY DISAGREE	6		6
			2.2
COLUMN TOTAL	271		271
	100.0		100.0

NUMBER OF MISSING OBSERVATIONS = 575

Table 32

CLINICAL NURSING RECORDS STUDY

"NURSING DISCHARGE SUMMARY (DA FORM 3888-5 TEST) - I LIKE TO HAVE THE DISCHARGE SUMMARY SERVE AS THE NURSING DISCHARGE NOTE" BY TYPE OF PROVIDER

C4	COUNT	TYPE 1 IRNS	11	ROW TOTAL
1 STRONGLY AGREE		152		152 55.1
2 AGREE		110		110 39.9
3 DISAGREE		9		9 3.3
4 STRONGLY DISAGRE		5		5 1.8
	COLUMN TOTAL	276 100.0		276 100.0

NUMBER OF MISSING OBSERVATIONS = 570

Table 33

CLINICAL NURSING RECORDS STUDY

"NURSING DISCHARGE SUMMARY (DA FORM 3888-5 TEST) -
IT IS HELPFUL TO HAVE A COPY FOR THE PATIENT"
BY TYPE OF PROVIDER

C5	COUNT	TYPE IRNS	POW	TOTAL
		1	11	
	1	143		143
STRONGLY AGREE				52.0
	2	116		116
AGREE				42.2
	3	10		10
DISAGREE				3.6
	4	6		6
STRONGLY DISAGREE				2.2
	COLUMN TOTAL	275 100.0		275 100.0

NUMBER OF MISSING OBSERVATIONS = 571

Table 34

CLINICAL NURSING RECORDS STUDY

"NURSING DISCHARGE SUMMARY (DA FORM 3888-5 TEST) - IT IS IMPORTANT FOR A NURSING SUMMARY TO APPEAR IN THE OUTPATIENT RECORD" BY TYPE OF PROVIDER

C6	TYPE		
COUNT	IRNS		ROW TOTAL
		11	
1 STRONGLY AGREE	102		102 37.8
2 AGREE	125		125 46.3
3 DISAGREE	31		31 11.5
4 STRONGLY DISAGREE	12		12 4.4
COLUMN TOTAL	270 100.0		270 100.0

NUMBER OF MISSING OBSERVATIONS = 576

Table 35

CLINICAL NURSING RECORDS STUDY

"NURSING DISCHARGE SUMMARY (DA FORM 3888-5 TEST) - THE NURSING DISCHARGE SUMMARY FORM NEEDS TO BE KEPT IN THE SYSTEM" BY TYPE OF PROVIDER

C7	COUNT	TYPE IKNS 1	ROK TOTAL
1 STRONGLY AGREE		114 41.9	114
2 AGREE		137 50.4	137
3 DISAGREE		14 5.1	14
4 STRONGLY DISAGREE		7 2.6	7
COLUMN TOTAL		272 100.0	272 100.0

NUMBER OF MISSING OBSERVATIONS = 574

Table 36

CLINICAL NURSING RECORDS STUDY

"NURSING DISCHARGE SUMMARY (DA FORM 3888-5 TEST) - DISCHARGE SUMMARIES SHOULD BE IN A MULTIDISCIPLINARY FORMAT SO PHYSICIANS AND OTHER HEALTH CARE PROVIDERS COULD MAKE APPROPRIATE NOTATIONS" BY TYPE OF PROVIDER

	TYPE	
COUNT	IRN'S	ROW TOTAL
OF	1	
1 STRONGLY AGREE	104	104
		37.5
2 AGREE	113	113
		40.8
3 DISAGREE	46	46
		16.6
4 STRONGLY DISAGREE	14	14
		5.1
COLUMN TOTAL	277	277
	100.0	100.0

NUMBER OF MISSING OBSERVATIONS = 569

Table 37

CINICAL NURSING RECORDS STUDY

"DOCTOR'S ORDERS MEDICATION/DOCTOR'S ORDERS NONMEDICATION

(DA FORM 4256-1 TEST; DA FORM 4256-2 TEST) -

WE FREQUENTLY USE THE BUFF COPY ON

NURSING UNIT" BY TYPE OF PROVIDER

D1	TYPE COUNT	IRNS 1	PARA 2	WARD CLERK 3	ROW TOTAL
1 STRONGLY AGREE	1	46	27	5	78 14.1
2 AGREE	2	86	92	7	185 33.4
3 DISAGREE	3	80	91	12	183 33.0
4 STRONGLY DISAGRE	4	78	22	8	108 19.5
	COLUMN TOTAL	290 52.3	232 41.9	32 5.8	554 100.0

NUMBER OF MISSING OBSERVATIONS = 292

Table 38

CINICAL NURSING RECORDS STUDY

"DOCTOR'S ORDERS MEDICATION/DOCTOR'S ORDERS NONMEDICATION (DA FORM 4256-1 TEST; DA FORM 4256-2 TEST) - I LIKE NOT HAVING TO RECOPY SOME SINGLE ACTION ORDERS ONTO THE THERAPEUTIC DOCUMENTATION CARE PLAN" BY TYPE OF PROVIDER

	TYPE			
COUNT	IRNS	FAFA	WARD CLERK	ROW TOTAL
	1	2	3	
1 STRONGLY AGREE	168	88	12	268 47.3
2 AGREE	82	121	17	220 38.8
3 DISAGREE	32	21	2	55 9.7
4 STRONGLY DISAGRE	12	10	2	24 4.2
COLUMN TOTAL	294 51.9	240 42.3	33 5.8	567 100.0

NUMBER OF MISSING OBSERVATIONS = 279

Table 39

CLINICAL NURSING RECORDS STUDY

"DURING THE TEST PERIOD, HOW OFTEN DID YOU USE THE NURSING HISTORY AND ASSESSMENT TO LEARN ABOUT NURSING ACTIVITIES AND THE PATIENT'S CONDITION?" BY TYPE OF PROVIDER

X1A	COUNT	TYPE PROFESSIONAL	4	FOR TOTAL
EVERY PNT	1	15		15 6.9
MOST PNTS	2	60		60 27.6
RARELY	3	95		95 43.8
NEVER	4	47		47 21.7
	COLUMN TOTAL	217 100.0		217 100.0

NUMBER OF MISSING OBSERVATIONS = 629

Table 40

CLINICAL NURSING RECORDS STUDY

"DURING THE TEST PERIOD, HOW OFTEN DID YOU USE THE NURSING CARE PLAN TO LEARN ABOUT NURSING ACTIVITY AND THE PATIENT'S CONDITION?" BY TYPE OF PROVIDER

		TYPE	
	COUNT	PROFESSIONAL	ROW TOTAL
X1E		4	
EVERY INT	1	6	6
			2.8
MOST PNTS	2	18	18
			8.3
RARELY	3	91	91
			41.7
NEVER	4	103	103
			47.2
	COLUMN TOTAL	218	218
		100.0	100.0

NUMBER OF MISSING OBSERVATIONS = 628

Table 41

CLINICAL NURSING RECORDS STUDY

"DURING THE TEST PERIOD, HOW OFTEN DID YOU USE THE NURSING DISCHARGE SUMMARY TO LEARN ABOUT NURSING ACTIVITIES AND THE PATIENT'S CONDITION?" BY TYPE OF PROVIDER

X1C	COUNT	TYPE PROFESSIONAL 41	ROW TOTAL
EVERY PNT	1	5 2.3	5 2.3
MOST PNTS	2	18 8.3	18 8.3
RARELY	3	89 41.2	89 41.2
NEVER	4	104 48.1	104 48.1
	COLUMN TOTAL	216 100.0	216 100.0

NUMBER OF MISSING OBSERVATIONS = 630

Table 42

CLINICAL NURSING RECORDS STUDY

"DURING THE TEST PERIOD, HOW OFTEN DID YOU USE THE THERAPEUTIC DOCUMENTATION CARE PLAN, NONMEDICATION?" BY TYPE OF PROVIDER

		TYPE	
	COUNT	1 PROFESSIONAL	ROW TOTAL
X1D		4	
1 EVERY PNT	1	30	30
			13.6
2 MOST PNTS	2	60	60
			27.3
3 RARELY	3	76	76
			34.5
4 NEVER	4	54	54
			24.5
	COLUMN TOTAL	220	220
		100.0	100.0

NUMBER OF MISSING OBSERVATIONS = 626

Table 43

CLINICAL NURSING RECORDS STUDY

"DURING THE TEST PERIOD, HOW OFTEN DID YOU USE THE THERAPEUTIC DOCUMENTATION CARE PLAN, MEDICATION?" BY TYPE OF PROVIDER

		TYPE	
	COUNT	PROFESSIONAL	ROW TOTAL
X1E		41	
EVERY PNT	1	47	47
			21.4
MOST PNTS	2	57	57
			25.9
RARELY	3	70	70
			31.8
NEVER	4	46	46
			20.9
	COLUMN TOTAL	220	220
		100.0	100.0

NUMBER OF MISSING OBSERVATIONS = 626

Table 44

CLINICAL NURSING RECORDS STUDY

"DURING THE TEST PERIOD, HOW OFTEN DID YOU USE THE TPR GRAPHIC?" BY TYPE OF PROVIDER

X1F	COUNT / COLUMN PCT	TYPE: PROFESSIONAL (1)	ROW TOTAL
EVERY PNT	1	134 61.8	134 61.8
MOST PNTS	2	41 18.9	41 18.9
RARELY	3	21 9.7	21 9.7
NEVER	4	21 9.7	21 9.7
	COLUMN TOTAL	217 100.0	217 100.0

NUMBER OF MISSING OBSERVATIONS = 629

Table 45

CLINICAL NURSING RECORDS STUDY

"DURING THE TEST PERIOD, HOW OFTEN DID YOU USE THE PROGRESS NOTES?" BY TYPE OF PROVIDER

		TYPE	
	COUNT	PROFESSIONAL	ROW TOTAL
		41	
X16			
	1	101	101
EVERY PNT			45.7
	2	61	61
MOST PNTS			27.6
	3	42	42
RARELY			19.0
	4	17	17
NEVER			7.7
	COLUMN TOTAL	221 100.0	221 100.0

NUMBER OF MISSING OBSERVATIONS = 625

Table 46

CLINICAL NURSING RECORDS STUDY

"DURING THE TEST PERIOD, HOW OFTEN DID YOU USE THE OTHER FORMS TO REVIEW NURSING CARE?"

BY TYPE OF PROVIDER

		TYPE	
	COUNT	PROFESSIONAL	ROW TOTAL
X1H		41	
1 EVERY PNT	1	5	5 16.1
2 MOST PNTS	2	1	1 3.2
3 RARELY	3	5	5 16.1
4 NEVER	4	20	20 64.5
	COLUMN TOTAL	31 100.0	31 100.0

NUMBER OF MISSING OBSERVATIONS = 815

Table 47

CLINICAL NURSING RECORDS STUDY

"PRIOR TO THE TEST PERIOD, HOW OFTEN HAD YOU USED THE NURSING HISTORY AND ASSESSMENT TO LEARN ABOUT NURSING ACTIVITIES AND THE PATIENT'S CONDITION?" BY TYPE OF PROVIDER

X3A	COUNT	TYPE PROFESSIONAL	ROW TOTAL
EVERY PNT	1	13	13
			6.3
MOST PNTS	2	46	46
			22.1
RARELY	3	99	99
			47.6
NEVER	4	50	50
			24.0
	COLUMN TOTAL	208	208
		100.0	100.0

NUMBER OF MISSING OBSERVATIONS = 638

Table 48

CLINICAL NURSING RECORDS STUDY

"PRIOR TO THE TEST PERIOD, HOW OFTEN HAD YOU USED THE NURSING CARE PLAN TO LEARN ABOUT NURSING ACTIVITIES AND THE PATIENT'S CONDITION?" BY TYPE OF PROVIDER

X3P	COUNT	TYPE PROFESSIONAL	ROW TOTAL
EVERY PNT	1	6 2.9	6 2.9
MOST PNTS	2	12 5.8	12 5.8
RARELY	3	92 44.2	92 44.2
NEVER	4	98 47.1	98 47.1
	COLUMN TOTAL	208 100.0	208 100.0

NUMBER OF MISSING OBSERVATIONS = 636

Table 49

CLINICAL NURSING RECORDS STUDY

"PRIOR TO THE TEST PERIOD, HOW OFTEN HAD YOU USED THE NURSING DISCHARGE SUMMARY TO LEARN ABOUT NURSING ACTIVITIES AND THE PATIENT'S CONDITION?" BY TYPE OF PROVIDER

		TYPE	
	COUNT	PROFESSIONAL	ROW TOTAL
X3C		4	
1 EVERY PNT	1	1	1
			.5
2 MOST PNTS	2	15	15
			7.2
3 RARELY	3	90	90
			43.5
4 NEVER	4	101	101
			48.8
	COLUMN TOTAL	207	207
		100.0	100.0

NUMBER OF MISSING OBSERVATIONS = 639

Table 50

CLINICAL NURSING RECORDS STUDY

"PRIOR TO THE TEST PERIOD, HOW OFTEN HAD YOU USED THE THERAPEUTIC DOCUMENTATION CARE PLAN, NONMEDICATION?" BY TYPE OF PROVIDER

X30	COUNT	TYPE PROFESSIONAL 4	ROW TOTAL
EVERY PAT	1	17 8.2	17 8.2
MOST PATS	2	46 22.2	46 22.2
RARELY	3	83 40.1	83 40.1
NEVER	4	61 29.5	61 29.5
	COLUMN TOTAL	207 100.0	207 100.0

NUMBER OF MISSING OBSERVATIONS = 639

Table 51

CLINICAL NURSING RECORDS STUDY

"PRIOR TO THE TEST PERIOD, HOW OFTEN HAD YOU USED THE THERAPEUTIC DOCUMENTATION CARE PLAN, MEDICATION?" BY TYPE OF PROVIDER

		TYPE	
	COUNT	PROFESSIONAL	ROW TOTAL
		41	
XBE			
	1	32	32
EVERY PNT			15.5
	2	54	54
MOST PNTS			26.1
	3	75	75
RARELY			36.2
	4	46	46
NEVER			22.2
	COLUMN TOTAL	207	207
		100.0	100.0

NUMBER OF MISSING OBSERVATIONS = 639

Table 52

CLINICAL NURSING RECORDS STUDY

"PRIOR TO THE TEST PERIOD, HOW OFTEN HAD YOU USED THE TPR GRAPHIC?" BY TYPE OF PROVIDER

X3F	COUNT / TYPE	PROFESSIONAL	41	ROW TOTAL
EVERY SHT	1	129		129
				61.7
MOST SHTS	2	37		37
				17.7
RARELY	3	25		25
				12.0
NEVER	4	18		18
				8.6
COLUMN TOTAL		209		209
		100.0		100.0

NUMBER OF MISSING OBSERVATIONS = 637

Table 53

CLINICAL NURSING RECORDS STUDY

"PRIOR TO THE TEST PERIOD, HOW OFTEN HAD YOU USED THE NURSING NOTES?" BY TYPE OF PROVIDER

X36	COUNT	TYPE PROFESSIONAL (1)	ROW TOTAL
EVERY PNT	1	43	43
			20.7
MOST PNTS	2	66	66
			31.7
RARELY	3	71	71
			34.1
NEVER	4	28	28
			13.5
COLUMN TOTAL		208	208
		100.0	100.0

NUMBER OF MISSING OBSERVATIONS = 636

Table 54

CLINICAL NURSING RECORDS STUDY

"PRIOR TO THE TEST PERIOD, HOW OFTEN DID YOU USE OTHER FORMS TO REVIEW NURSING CARE?"

BY TYPE OF PROVIDER

X3R	COUNT	TYPE PROFESSIONAL 4	ROW TOTAL
1 EVERY PAT		3 10.0	3 10.0
2 MOST PATS		1 3.3	1 3.3
3 RARELY		8 26.7	8 26.7
4 NEVER		18 60.0	18 60.0
COLUMN TOTAL		30 100.0	30 100.0

NUMBER OF MISSING OBSERVATIONS = 816

Table 55

CLINICAL NURSING RECORDS STUDY

"DOCTOR'S ORDERS MEDICATION/DOCTOR'S ORDERS NONMEDICATION (DA FORM 4256-1 TEST; DA FORM 4256-2 TEST) - HAVING TWO SEPARATE ORDER SHEETS CAUSED MINIMAL DIFFICULTIES FOR ME" BY TYPE OF PROVIDER

D3	COUNT / TYPE	IRNS 1	PAPA 2	WARD CLERK 3	PROFES-SIONAL 4	ROW TOTAL
1		93	82	11	29	215
STRONGLY AGREE						27.0
2		133	132	14	72	351
AGREE						44.2
3		44	27	5	57	133
DISAGREE						16.7
4		40	6	3	47	96
STRONGLY DISAGREE						12.1
	COLUMN TOTAL	310	247	33	205	795
		39.0	31.1	4.2	25.8	100.0

NUMBER OF MISSING OBSERVATIONS = 51

Table 56

CLINICAL NURSING RECORDS STUDY

"DOCTOR'S ORDERS MEDICATION/DOCTOR'S ORDERS NONMEDICATION (DA FORM 4256-1 TEST; DA FORM 4256-2 TEST) - ORDERS SHOULD CONTINUE TO REMAIN SEPARATED ON COLOR CODED MEDICATION AND NONMEDICATION SHEETS"

BY TYPE OF PROVIDER

D4	COUNT / TYPE	IRNS 1	FAPA 11	WARD CLERK 21	PROFES-SIONAL 31	ROW TOTAL
1 STRONGLY AGREE		140	128	17	27	312
						39.5
2 AGREE		96	105	13	72	286
						36.2
3 DISAGREE		31	13	2	41	87
						11.0
4 STRONGLY DISAGREE		38	2	3	62	105
						13.3
	COLUMN TOTAL	305	248	35	202	790
		38.6	31.4	4.4	25.6	100.0

NUMBER OF MISSING OBSERVATIONS = 56

Table 57

CLINICAL NURSING RECORDS STUDY

"DOCTOR'S ORDERS MEDICATION/DOCTOR'S ORDERS NONMEDICATION (DA FORM 4256-1 TEST; DA FORM 4256-2 TEST) - PRIOR TO THE TEST PERIOD, IF UNFAMILIAR WITH A PATIENT, I MOST OFTEN DETERMINED CURRENT MEDICATION(S) BY . . ."

BY TYPE OF PROVIDER

D6	COUNT	TYPE PROFESSIONAL 4	ROW TOTAL
REVIEW ALL DR OR	1	84	84 41.8
REVIEW TD-MED	2	85	85 42.3
ASK NURSE	3	20	20 10.0
OTHER	4	12	12 6.0
	COLUMN TOTAL	201 100.0	201 100.0

NUMBER OF MISSING OBSERVATIONS = 645

Table 58

CLINICAL NURSING RECORDS STUDY

"DOCTOR'S ORDERS MEDICATION/DOCTOR'S ORDERS NONMEDICATION (DA FORM 4256-1 TEST; DA FORM 4256-2 TEST) - DURING THE TEST PERIOD, AFTER THE SEPARATION OF ORDERS, IF UNFAMILIAR WITH A PATIENT, I MOST OFTEN DETERMINED CURRENT MEDICATION(S) BY . . ." BY TYPE OF PROVIDER

D7	COUNT	TYPE PROFESSIONAL	ROW TOTAL
REVIEW ALL DR ORDERS	1	104 51.0	104 51.0
REVIEW TO-MED	2	73 35.8	73 35.8
ASK NURSE	3	18 8.8	18 8.8
OTHER	4	9 4.4	9 4.4
COLUMN TOTAL		204 100.0	204 100.0

NUMBER OF MISSING OBSERVATIONS = 642

Table 59

CLINICAL NURSING RECORDS STUDY

"DOCTOR'S ORDERS MEDICATION/DOCTOR'S ORDERS NONMEDICATION (DA FORM 4256-1 TEST; DA FORM 4256-2 TEST) - IF WE WENT BACK TO THE 'OLD' ORDER SHEETS, I WOULD HAVE NO DIFFICULTY IDENTIFYING COMPLETED SINGLE ACTION ORDERS" BY TYPE OF PROVIDER

	TYPE			
COUNT	IRNS	PARA	WARD CLERK	ROW TOTAL
DB	1I	2I	3I	
1 STRONGLY AGREE	50	25	6	81
				14.2
2 AGREE	102	87	15	204
				35.7
3 DISAGREE	110	101	9	220
				38.5
4 STRONGLY DISAGRE	34	30	2	66
				11.6
COLUMN TOTAL	296	243	32	571
	51.8	42.6	5.6	100.0

NUMBER OF MISSING OBSERVATIONS = 275

Table 60

CLINICAL NURSING RECORDS STUDY

"DOCTOR'S ORDERS MEDICATION/DOCTOR'S ORDERS NONMEDICATION (DA FORM 4256-1 TEST; DA FORM 4256-2 TEST) - IF WE WENT BACK TO THE 'OLD' ORDER SHEETS, I WOULD STILL WANT A COLUMN FOR SINGLE ACTION ORDERS TO PRECLUDE MY HAVING TO RECOPY THEM ONTO THE THERAPEUTIC DOCUMENTATION CARE PLANS" BY TYPE OF PROVIDER

	TYPE			
COUNT	IRNS	LPN	WARD CLERK	ROW TOTAL
	1	2	3	
Q9				
1 STRONGLY AGREE	165	76	14	255
				44.6
2 AGREE	89	129	16	234
				40.9
3 DISAGREE	38	27	1	66
				11.5
4 STRONGLY DISAGREE	7	7	3	17
				3.0
COLUMN TOTAL	299	239	34	572
	52.3	41.8	5.9	100.0

NUMBER OF MISSING OBSERVATIONS = 274

Table 61

CLINICAL NURSING RECORDS STUDY

I LIKE BEING ABLE TO DOCUMENT (WITH EFFECTIVENESS CODES OR KEY WORDS) THE PATIENT'S RESPONSE DIRECTLY ON THE THERAPEUTIC DOCUMENTATION CARE PLANS" BY TYPE OF PROVIDER

E1	TYPE COUNT	IRNS 1	PARA 2	ROW TOTAL
1 STRONGLY AGREE		148	63	211 39.4
2 AGREE		125	157	282 52.7
3 DISAGREE		15	20	35 6.5
4 STRONGLY DISAGRL		5	2	7 1.3
	COLUMN TOTAL	293 54.8	242 45.2	535 100.0

NUMBER OF MISSING OBSERVATIONS = 311

Table 62

CLINICAL NURSING RECORDS STUDY

"MOST OF MY DOCUMENTATION IS RECORDED ON THE THERAPEUTIC DOCUMENTATION CARE PLANS" BY TYPE OF PROVIDER

E2	COUNT	TYPE PARA 2	ROW TOTAL
1 STRONGLY AGREE		40 17.2	40 17.2
2 AGREE		133 57.3	133 57.3
3 DISAGREE		52 22.4	52 22.4
4 STRONGLY DISAGREE		7 3.0	7 3.0
COLUMN TOTAL		232 100.0	232 100.0

NUMBER OF MISSING OBSERVATIONS = 614

Table 63

CLINICAL NURSING RECORDS STUDY

"IN THE PAST, I USED TO DO MOST OF MY DOCUMENTING ON THE NURSING NOTES (SF 510)" BY TYPE OF PROVIDER

E3	COUNT / TYPE	PARA (2)	ROW TOTAL
1 STRONGLY AGREE		88	88
			36.1
2 AGREE		147	147
			60.2
3 DISAGREE		5	5
			2.0
4 STRONGLY DISAGREE		4	4
			1.6
	COLUMN TOTAL	244	244
		100.0	100.0

NUMBER OF MISSING OBSERVATIONS = 602

Table 64

CLINICAL NURSING RECORDS STUDY

"RECORDING THE PATIENT'S RESPONSE ON THE TD CARE PLAN IMPROVES MY DOCUMENTATION OF PATIENT CARE"

BY TYPE OF PROVIDER

E4	COUNT	TYPE: RNS (1)	TYPE: PARA (2)	ROW TOTAL
1 STRONGLY AGREE		89	53	142
				26.5
2 AGREE		156	153	311
				58.1
3 DISAGREE		48	35	75
				14.0
4 STRONGLY DISAGREE		6	1	7
				1.3
	COLUMN TOTAL	293	242	535
		54.8	45.2	100.0

NUMBER OF MISSING OBSERVATIONS = 511

Table 65

CLINICAL NURSING RECORDS STUDY

"RECORDING THE PATIENT'S RESPONSE ON THE THERAPEUTIC DOCUMENTATION CARE PLAN ENCOURACES ME TO WRITE MORE NURSING ORDERS TO DESCRIBE NURSING ACTIVITIES WITH THE PATIENT" BY TYPE OF PROVIDER."

	TYPE	
COUNT	IRNS	FOR TOTAL
EF	1I	
1 STRONGLY AGREE	78	78 27.2
2 AGREE	142	142 49.5
3 DISAGREE	60	60 20.9
4 STRONGLY DISAGREE	7	7 2.4
COLUMN TOTAL	287 100.0	287 100.0

NUMBER OF MISSING OBSERVATIONS = 559

Table 66

CLINICAL NURSING RECORDS STUDY

"RECORDING THE PATIENT'S RESPONSE ON THE THERAPEUTIC DOCUMENTATION CARE PLAN IMPROVES COMMUNICATION AMONG NURSING PERSONNEL" BY TYPE OF PROVIDER

EC	COUNT	TYPE I RNS 1	PARA 2	ROW TOTAL
STRONGLY AGREE	1	74	50	124
				23.0
AGREE	2	166	157	323
				59.9
DISAGREE	3	47	37	84
				15.6
STRONGLY DISAGREE	4	5	3	8
				1.5
	COLUMN TOTAL	292	247	539
		54.2	45.8	100.0

NUMBER OF MISSING OBSERVATIONS = 307

Table 67

CLINICAL NURSING RECORDS STUDY

"RECORDING THE PATIENT'S RESPONSE ON THE THERAPEUTIC DOCUMENTATION CARE PLAN IMPROVES COMMUNICATION BETWEEN NURSES AND OTHER HEALTH CARE PROVIDERS"

BY TYPE OF PROVIDER

E7	COUNT / TYPE	IRNS	PARA	ROW TOTAL
		1	2	
1		49	46	95
STRONGLY AGREE				17.7
2		144	151	295
AGREE				54.9
3		88	44	132
DISAGREE				24.6
4		11	4	15
STRONGLY DISAGRE				2.8
	COLUMN TOTAL	292	245	537
		54.4	45.6	100.0

NUMBER OF MISSING OBSERVATIONS = 309

Table 68

CLINICAL NURSING RECORDS STUDY

"RECORDING THE PATIENT'S RESPONSE ON THE TD CARE PLAN HAS DECREASED FRAGMENTED DOCUMENTATION IN THE RECORD"

BY TYPE OF PROVIDER

EE	COUNT	TYPE IRNS I	PARA II	PARA 2I	ROW TOTAL
STRONGLY AGREE	1	64	44		108
					20.4
AGREE	2	170	152		322
					60.8
DISAGREE	3	47	43		90
					17.0
STRONGLY DISAGREE	4	8	2		10
					1.9
	COLUMN TOTAL	289	241		530
		54.5	45.5		100.0

NUMBER OF MISSING OBSERVATIONS = 316

Table 69

CLINICAL NURSING RECORDS STUDY

"RECORDING THE PATIENT'S RESPONSE ON THE TD CARE PLAN ALLOWS ME TO GIVE A MORE THOROUGH REPORT"

BY TYPE OF PROVIDER

		TYPE	
	COUNT	I	
		IRNS	ROW
		I	TOTAL
		I 1I	
E?	--------+--------+		
	1	I 68 I	68
STRONGLY AGREE		I I	23.7
		+--------+	
	2	I 154 I	154
AGREE		I I	53.7
		+--------+	
	3	I 61 I	61
DISAGREE		I I	21.3
		+--------+	
	4	I 4 I	4
STRONGLY DISAGRE		I I	1.4
		+--------+	
	COLUMN	287	287
	TOTAL	100.0	100.0

NUMBER OF MISSING OBSERVATIONS = 559

Table 70

CLINICAL NURSING RECORDS STUDY

"RECORDING THE PATIENT'S RESPONSE ON THE TD CARE PLAN GIVES ME A BETTER 'PICTURE' OF WHAT HAPPENED TO THE PATIENT" BY TYPE OF PROVIDER

E10	COUNT	TYPE 1 IRNS	1I PAFA	2I RCh	TOTAL
STRONGLY AGREE	1	62	48		110
					20.4
AGREE	2	171	157		328
					61.0
DISAGREE	3	53	39		92
					17.1
STRONGLY DISAGRE	4	6	2		8
					1.5
	COLUMN TOTAL	292	246		538
		54.3	45.7		100.0

NUMBER OF MISSING OBSERVATIONS = 308

Table 71

CLINICAL NURSING RECORDS STUDY

"I DID NOT DOCUMENT PATIENT RESPONSES ON THE THERAPUETIC DOCUMENTATION CARE PLANS" BY TYPE OF PROVIDER

E11	TYPE			
COUNT	IRNS	PAPA		ROW TOTAL
	1I	2I		
1 STRONGLY AGREE	5	5		10 2.0
2 AGREE	37	65		102 20.0
3 DISAGREE	163	135		298 58.5
4 STRONGLY DISAGRE	74	25		99 19.4
COLUMN TOTAL	279 54.8	230 45.2		509 100.0

NUMBER OF MISSING OBSERVATIONS = 337

Table 72

CLINICAL NURSING RECORDS STUDY

"I HAD MINIMAL DIFFICULTY RECORDING THE PATIENT'S RESPONSES ON THE THERAPEUTIC DOCUMENTATION CARE PLAN" BY TYPE OF PROVIDER

E12	COUNT	TYPE 11 RNS	21 PARA	ROW TOTAL
1 STRONGLY AGREE		56	24	80 15.6
2 AGREE		162	160	322 62.8
3 DISAGREE		55	42	97 18.9
4 STRONGLY DISAGRE		9	5	14 2.7
	COLUMN TOTAL	282 55.0	231 45.0	513 100.0

NUMBER OF MISSING OBSERVATIONS = 333

Table 73

CLINICAL NURSING RECORDS STUDY

"THE EXPANDED USE OF THE THERAPEUTIC DOCUMENTATION CARE PLAN (BEING ABLE TO DOCUMENT RESPONSES) IS A CONCEPT WHICH SHOULD BE AVAILABLE TO ALL NURSING PERSONNEL WORLDWIDE"

BY TYPE OF PROVIDER

E13	COUNT / TYPE	INS (1)	PARA (2)	ROW TOTAL
1 STRONGLY AGREE		119	56	175
				33.9
2 AGREE		137	154	291
				56.4
3 DISAGREE		23	18	41
				7.9
4 STRONGLY DISAGRE		6	3	9
				1.7
COLUMN TOTAL		285	231	516
		55.2	44.8	100.0

NUMBER OF MISSING OBSERVATIONS = 330

Table 74

CLINICAL NURSING RECORDS STUDY

"THE 'FOLDER' TYPE FORMAT OF THE THERAPEUTIC DOCUMENTATION CARE PLANS IS AN IMPROVEMENT" BY TYPE OF PROVIDER

E14	TYPE: RNS (1)	PARA (2)	WARD CLERK (3)	ROW TOTAL
1 STRONGLY AGREE	90	79	16	185
				31.7
2 AGREE	136	140	15	291
				49.9
3 DISAGREE	55	24	2	81
				13.9
4 STRONGLY DISAGREE	13	11	2	26
				4.5
COLUMN TOTAL	294	254	35	583
	50.4	43.6	6.0	100.0

NUMBER OF MISSING OBSERVATIONS = 263

Table 75

CLINICAL NURSING RECORDS STUDY

"THE 'FOLDER' TYPE FORMAT OF THE THERAPEUTIC DOCUMENTATION CARE PLANS SHOULD BE KEPT EVEN IF IT CANNOT BE OVERPRINTED WITH ORDERS" BY TYPE OF PROVIDER

L15	TYPE COUNT	1 IRN.S	PARA	WARD CLERK	3	ROW TOTAL
		1	11	21		
1		71	57	8		136
STRONGLY AGREE						23.9
2		124	136	15		275
AGREE						48.2
3		67	44	8		119
DISAGREE						20.9
4		25	14	1		40
STRONGLY DISAGREE						7.0
COLUMN TOTAL		287 50.4	251 44.0	32 5.6		570 100.0

NUMBER OF MISSING OBSERVATIONS = 276

Table 76

CLINICAL NURSING RECORDS STUDY

"THE 'FOLDER' TYPE FORMAT OF THE THERAPEUTIC DOCUMENTATION CARE PLANS SHOULD HAVE THE PATIENT IDENTIFICATION BLOCK PRINTED ON ALL PAGES" BY TYPE OF PROVIDER

E16	TYPE COUNT	1 IRNS	11	FARA	21	WARD CLERK	31	ROW TOTAL
1		67		66		4		139
STRONGLY AGREE								23.9
2		108		101		9		218
AGREE								37.5
3		101		72		15		188
DISAGREE								32.3
4		20		12		5		37
STRONGLY DISAGREE								6.4
COLUMN TOTAL		296		253		33		582
		50.9		43.5		5.7		100.0

NUMBER OF MISSING OBSERVATIONS = 264

Table 77

CLINICAL NURSING RECORDS STUDY

"I LIKE THE STURDIER PAPER ON WHICH THE FORMS ARE PRINTED"

BY TYPE OF PROVIDER

E17	COUNT	TYPE 1 IRNS	PAFA 2	WARD CLERK 3	ROW TOTAL
1 STRONGLY AGREE		143	99	12	254 43.5
2 AGREE		126	134	19	279 47.8
3 DISAGREE		21	16	2	41 7.0
4 STRONGLY DISAGREE		8	1	1	10 1.7
COLUMN TOTAL		298 51.0	252 43.2	34 5.8	584 100.0

NUMBER OF MISSING OBSERVATIONS = 262

Table 78

CLINICAL NURSING RECORDS STUDY

"HAVING SEPARATE PAGES FOR RECURRING, DELAYED, OR PRN ACTION ORDERS IS HELPFUL TO ME" BY TYPE OF PROVIDER

E1E	COUNT	TYPE: IRNS (1)	PARA (2)	WARD CLERK (3)	ROW TOTAL
1 STRONGLY AGREE	1	121	76	13	210
					37.4
2 AGREE	2	141	141	18	300
					53.5
3 DISAGREE	3	20	18	1	39
					7.0
4 STRONGLY DISAGRE	4	7	4	1	12
					2.1
COLUMN TOTAL		289	239	33	561
		51.5	42.6	5.9	100.0

NUMBER OF MISSING OBSERVATIONS = 285

Table 79

CLINICAL NURSING RECORDS STUDY

"TO MY KNOWLEDGE, THERE WERE NO TREATMENT OR MEDICATION ERRORS COMMITTED ON MY NURSING UNIT WHICH COULD BE BLAMED ON THE NEW FORMAT OF THE THERAPEUTIC DOCUMENTATION CARE PLANS" BY TYPE OF PROVIDER

E19	TYPE COUNT	IRNS 1	PARA 2	ROW TOTAL
STRONGLY AGREE	1	84	63	147 28.1
AGREE	2	122	130	252 48.1
DISAGREE	3	62	35	97 18.5
STRONGLY DISAGREE	4	20	8	28 5.3
	COLUMN TOTAL	288 55.0	236 45.0	524 100.0

NUMBER OF MISSING OBSERVATIONS = 322

Table 80

CLINICAL NURSING RECORDS STUDY

"I WOULD PREFER TO HAVE THE THERAPEUTIC DOCUMENTATION CARE PLANS IN A SINGLE SHEET FORMAT (LIKE THE 'OLD' TDs) EVEN KNOWING THAT I WOULD HAVE LESS ROOM FOR DOCUMENTATION" BY TYPE OF PROVIDER

E2C	COUNT	TYPE 1 RNS	2 LPN	3 WARD CLERK	ROW TOTAL
1 STRONGLY AGREE		22	14	1	37 6.7
2 AGREE		39	56	8	97 17.5
3 DISAGREE		152	134	18	304 54.9
4 STRONGLY DISAGREE		74	38	4	116 20.9
	COLUMN TOTAL	287 51.8	236 42.6	31 5.6	554 100.0

NUMBER OF MISSING OBSERVATIONS = 292

Table 81

CLINICAL NURSING RECORDS STUDY

"IF A SINGLE SHEET FORMAT WERE TO BE USED, I WOULD PREFER A MEDIUM WEIGHT PAPER (LESS BULKY THAN THE TESTED PAPER)" BY TYPE OF PROVIDER

E21	TYPE COUNT IRNS 1	PARA 2	WARD CLERK 3	ROW TOTAL
1 STRONGLY AGREE	21	12	3	36 6.5
2 AGREE	59	71	10	140 25.2
3 DISAGREE	163	127	18	308 55.4
4 STRONGLY DISAGRE	43	27	2	72 12.9
COLUMN TOTAL	286 51.4	237 42.6	33 5.9	556 100.0

NUMBER OF MISSING OBSERVATIONS = 290

Table 82

CLINICAL NURSING RECORDS STUDY

"ALL MEDICATION AND NONMEDICATION FORMS SHOULD REMAIN COLOR CODED" BY TYPE OF PROVIDER

E22	COUNT	TYPE: RNS (1)	PARA (2)	WARD CLERK (3)
1 STRONGLY AGREE		182	124	21
2 AGREE		108	121	14
3 DISAGREE		9	3	
4 STRONGLY DISAGREE		3		
	COLUMN TOTAL	296	248	35
		51.1	42.8	6.0

NUMBER OF MISSING OBSERVATIONS = 267

Table 83

CLINICAL NURSING RECORDS STUDY

"YELLOW HIGHLIGHTER USE SHOULD BE REINSTATED TO DISCONTINUE ORDERS" BY TYPE OF PROVIDER

E23	COUNT	TYPE 1 RNS	2 LPN	3 WARD CLERK
1 STRONGLY AGREE		158	110	13
2 AGREE		68	87	10
3 DISAGREE		49	36	6
4 STRONGLY DISAGREE		22	14	5
	COLUMN TOTAL	297 51.4	247 42.7	34 5.9

NUMBER OF MISSING OBSERVATIONS = 266

Table 84

CLINICAL NURSING RECORDS STUDY

"THE INTEGRATED PROGRESS NOTE IMPROVES COMMUNICATIONS CONCERNING THE PATIENT AMONG ALL HEALTH CARE PROVIDERS" BY TYPE OF PROVIDER

F1	COUNT	TYPE 1 IRNS	1I	PAPA 2I	4I	PROFESSIONAL
STRONGLY AGREE	1	136		89		67
AGREE	2	133		136		88
DISAGREE	3	24		19		42
STRONGLY DISAGREE	4	10		3		22
	COLUMN TOTAL	303 39.4		247 32.1		219 28.5

NUMBER OF MISSING OBSERVATIONS = 77

Table 85

CLINICAL NURSING RECORDS STUDY

"THE INTEGRATED PROGRESS NOTE HAS ENCOURAGED ME TO BE MORE THOROUGH IN DOCUMENTATION" BY TYPE OF PROVIDER

F2	COUNT	TYPE 1 RNS	2 PAPA	ROW TOTAL
1	STRONGLY AGREE	98	69	167 30.4
2	AGREE	121	143	264 48.0
3	DISAGREE	69	37	106 19.3
4	STRONGLY DISAGRE	12	1	13 2.4
	COLUMN TOTAL	300 54.5	250 45.5	550 100.0

NUMBER OF MISSING OBSERVATIONS = 296

Table 36

CLINICAL NURSING RECORDS STUDY

"THE INTEGRATED PROGRESS NOTE HAS ENCOURAGED ME TO BE MORE CONCISE IN DOCUMENTATION" BY TYPE OF PROVIDER

F3	COUNT	TYPE: RNS (1)	TYPE: PARA (2)	ROW TOTAL
STRONGLY AGREE	1	99	62	161
				29.4
AGREE	2	165	159	324
				59.2
DISAGREE	3	28	25	53
				9.7
STRONGLY DISAGREE	4	8	1	9
				1.6
	COLUMN TOTAL	300	247	547
		54.8	45.2	100.0

NUMBER OF MISSING OBSERVATIONS = 299

Table 87

CLINICAL NURSING RECORDS STUDY

"THE INTEGRATED PROGRESS NOTE LESSENS FRAGMENTING OF INFORMATION IN THE PATIENT RECORD"

BY TYPE OF PROVIDER

F4	COUNT / TYPE	1 IRNS	2 PARA	4 PROFESSIONAL	ROW TOTAL
1	STRONGLY AGREE	113	65	64	242
					31.6
2	AGREE	159	153	84	396
					51.6
3	DISAGREE	24	27	46	97
					12.6
4	STRONGLY DISAGREE	7	1	24	32
					4.2
	COLUMN TOTAL	303	246	218	767
		39.5	32.1	28.4	100.0

NUMBER OF MISSING OBSERVATIONS = 79

Table 88

CLINICAL NURSING RECORDS STUDY

"THE INTEGRATED PROGRESS NOTE LESSENS THE AMOUNT OF INFORMATION EVERYONE MUST DOCUMENT"

BY TYPE OF PROVIDER

F!	TYPE COUNT	IRNS 1	PARA 2	PROFESSIONAL 4	ROW TOTAL
1 STRONGLY AGREE	1	103	64	28	195
					25.4
2 AGREE	2	149	133	57	339
					44.2
3 DISAGREE	3	40	48	96	184
					24.0
4 STRONGLY DISAGRE	4	11	2	36	49
					6.4
	COLUMN TOTAL	303 39.5	247 32.2	217 28.3	767 100.0

NUMBER OF MISSING OBSERVATIONS = 79

Table 89

CLINICAL NURSING RECORDS STUDY

"THE INTEGRATED PROGRESS NOTE ENCOURAGES ME TO READ NARRATIVE NURSING NOTES MORE THAN I DID IN THE PAST" BY TYPE OF PROVIDER

F6	COUNT	TYPE 41 PROFESSIONAL	ROW TOTAL
STRONGLY AGREE	1	48	48
			21.9
AGREE	2	93	93
			42.5
DISAGREE	3	50	50
			22.8
STRONGLY DISAGREE	4	28	28
			12.8
	COLUMN TOTAL	219 100.0	219 100.0

NUMBER OF MISSING OBSERVATIONS = 627

Table 90

CLINICAL NURSING RECORDS STUDY

"THE INTEGRATED PROGRESS NOTE MAKES IT EASIER TO DETERMINE WHAT IS HAPPENING WITH MY PATIENT"

BY TYPE OF PROVIDER

F7	COUNT	TYPE PROFESSIONAL 1	ROW TOTAL
STRONGLY AGREE	1	44	44 20.0
AGREE	2	92	92 41.8
DISAGREE	3	54	54 24.5
STRONGLY DISAGREE	4	30	30 13.6
	COLUMN TOTAL	220 100.0	220 100.0

NUMBER OF MISSING OBSERVATIONS = 626

Table 91

CLINICAL NURSING RECORDS STUDY

"THE INTEGRATED PROGRESS NOTE HAS SAVED ME TIME IN DOCUMENTING (I FEEL I DON'T NEED TO REPEAT INFORMATION PREVIOUSLY DOCUMENTED BY ANOTHER HEALTH CARE PROVIDER BECAUSE IT'S ALL IN THE SAME PLACE)" BY TYPE OF PROVIDER

FE	TYPE	IRNS (1)	PARA (2)	ROW TOTAL
STRONGLY AGREE	1	132	84	216
				39.9
AGREE	2	124	125	249
				46.0
DISAGREE	3	30	28	58
				10.7
STRONGLY DISAGRE	4	12	6	18
				3.3
	COLUMN TOTAL	298	243	541
		55.1	44.9	100.0

NUMBER OF MISSING OBSERVATIONS = 305

Table 92

CLINICAL NURSING RECORDS STUDY

"THE INTEGRATED PROGRESS NOTE ENCOURAGES ME TO READ OTHER CARE PROVIDERS' NOTES" BY TYPE OF PROVIDER

	TYPE		
COUNT	IRNS	PARA	ROW TOTAL
	1	2	
F' 1 STRONGLY AGREE	146	78	224
			40.3
2 AGREE	137	147	284
			51.1
3 DISAGREE	19	22	41
			7.4
4 STRONGLY DISAGRE	5	2	7
			1.3
COLUMN TOTAL	307	249	556
	55.2	44.8	100.0

NUMBER OF MISSING OBSERVATIONS = 290

Table 93

CLINICAL NURSING RECORDS STUDY

"THE INTEGRATED PROGRESS NOTE SHOULD BE USED AT ALL ARMY HOSPITALS" BY TYPE OF PROVIDER

F10	COUNT	TYPE IRNS 1	PARA 2	PROFESSIONAL 4	ROW TOTAL
1 STRONGLY AGREE		168	100	54	322
					42.3
2 AGREE		117	131	78	326
					42.8
3 DISAGREE		12	12	38	62
					8.1
4 STRONGLY DISAGRE		5	2	44	51
					6.7
	COLUMN TOTAL	302	245	214	761
		39.7	32.2	28.1	100.0

NUMBER OF MISSING OBSERVATIONS = 85

Table 94

CLINICAL NURSING RECORDS STUDY

"I HAD LITTLE DIFFICULTY IDENTIFYING WHO WROTE PREVIOUS NARRATIVE NOTATIONS" BY TYPE OF PROVIDER

F11	COUNT	TYPE 4	ROW TOTAL
STRONGLY AGREE	1	32	32
			14.8
AGREE	2	126	126
			58.3
DISAGREE	3	42	42
			19.4
STRONGLY DISAGRE	4	16	16
			7.4
	COLUMN TOTAL	216	216
		100.0	100.0

NUMBER OF MISSING OBSERVATIONS = 630

Table 95

CLINICAL NURSING RECORDS STUDY

"I HAD NO DIFFICULTY DISTINGUISHING NURSING NOTATIONS FROM THOSE OF OTHER DISCIPLINES" BY TYPE OF PROVIDER

F12	COUNT	TYPE IRNS 1	PARA 2	PROFESSIONAL 4	ROW TOTAL
1 STRONGLY AGREE		135	62	43	240
		31.5			
2 AGREE		147	148	137	432
		56.6			
3 DISAGREE		18	32	28	78
		10.2			
4 STRONGLY DISAGRE		5	2	6	13
		1.7			
COLUMN TOTAL		305	244	214	763
		40.0	32.0	28.0	100.0

NUMBER OF MISSING OBSERVATIONS = 83

Table 96

CLINICAL NURSING RECORDS STUDY

"I HAD LITTLE DIFFICULTY LOCATING MY PREVIOUS NARRATIVE NOTATIONS" BY TYPE OF PROVIDER

F13	COUNT	TYPE 1 PROFESSIONAL 41	ROW TOTAL
STRONGLY AGREE	1	48	48
			22.3
AGREE	2	116	116
			54.0
DISAGREE	3	35	35
			16.3
STRONGLY DISAGREE	4	15	15
			7.0
	6	1	1
			.5
	COLUMN TOTAL	215 100.0	215 100.0

NUMBER OF MISSING OBSERVATIONS = 631

Table 97

CLINICAL NURSING RECORDS STUDY

"PHYSICIANS ON MY NURSING UNIT SEEMED TO LIKE HAVING NARRATIVE NURSING COMMENTS INTEGRATED WITH OTHER PATIENT CARE DOCUMENTATION"

BY TYPE OF PROVIDER

F14	COUNT	TYPE: RNS (1)	TYPE: PARA (2)	RDN TOTAL
1 STRONGLY AGREE		46	32	78
				15.8
2 AGREE		150	142	292
				59.2
3 DISAGREE		63	34	97
				19.7
4 STRONGLY DISAGRE		16	10	26
				5.3
	COLUMN TOTAL	275	218	493
		55.8	44.2	100.0

NUMBER OF MISSING OBSERVATIONS = 353

Table 98

CLINICAL NURSING RECORDS STUDY

"OTHER HEALTH CARE PROVIDERS (e.g., PHYSICAL THERAPIST, DIETITIAN, SOCIAL WORKER) SEEMED TO LIKE HAVING NARRATIVE NURSING COMMENTS INTEGRATED WITH OTHER PATIENT CARE DOCUMENTATION"

BY TYPE OF PROVIDER

F15	TYPE COUNT IRNS 1	PARA 11	PARA 21	ROW TOTAL
1 STRONGLY AGREE	45	39		84 17.7
2 AGREE	181	154		335 70.5
3 DISAGREE	28	18		46 9.7
4 STRONGLY DISAGRE	6	4		10 2.1
COLUMN TOTAL	260 54.7	215 45.3		475 100.0

NUMBER OF MISSING OBSERVATIONS = 371

Table 99

CLINICAL NURSING RECORDS STUDY

"ALTHOUGH THE GUIDELINES READ THAT ALL NURSING PERSONNEL WERE AUTHORIZED TO CHART ON THE PROGRESS NOTES, THERE WERE SOME EXCEPTIONS TO THIS POLICY ON MY NURSING UNIT" BY TYPE OF PROVIDER

F16	TYPE COUNT IRNS 1	PARA 11	21	ROW TOTAL
1 STRONGLY AGREE	14	19		33 6.3
2 AGREE	49	65		114 21.8
3 DISAGREE	148	120		268 51.2
4 STRONGLY DISAGREE	73	35		108 20.7
COLUMN TOTAL	284 54.3	239 45.7		523 100.0

NUMBER OF MISSING OBSERVATIONS = 323

Table 100

CLINICAL NURSING RECORDS STUDY

"IN MY OPINION, THE BOTTOM LINE TO EVERYTHING WE HAVE TESTED IS. . ." BY TYPE OF PROVIDER

G1	TYPE			
COUNT	IRNS	PARA	WARD CLERK	ROW TOTAL
	1	2	3	
1 IMPLEMENT EXACTL	111	138	14	263
				53.1
2 GO BACK TO OLD	3	6	3	12
				2.4
3 IMPLEMENT W MODI	147	62	11	220
				44.4
COLUMN TOTAL	261	206	28	495
	52.7	41.6	5.7	100.0

NUMBER OF MISSING OBSERVATIONS = 351

Table 101

CLINICAL NURSING RECORDS STUDY

GENERAL COMMENTS REGARDING THE TEST FORMS

BY TYPE OF PROVIDER

COMMENTS	TYPE: IRN	PARA	WARD CLERK	PROFESSIONAL	ROW TOTAL
1 DR ORDER +GEN SAT	13	28	11	11	63
	20.6	44.4	17.5	17.5	17.0
	18.3	17.5	15.3	16.2	
	3.5	7.5	3.0	3.0	
2 DR ORD +SINGLE ACT	1	6	0	3	10
	10.0	60.0	0.0	30.0	2.7
	1.4	3.8	0.0	4.4	
	0.3	1.6	0.0	0.8	
3 DR ORD+EASY REFER	0	7	2	0	9
	0.0	77.8	22.2	0.0	2.4
	0.0	4.4	2.8	0.0	
	0.0	1.9	0.5	0.0	
4 DR ORD-GEN-PAPERWRK	3	14	5	2	24
	12.5	58.3	20.8	8.3	6.5
	4.2	8.8	6.9	2.9	
	0.8	3.8	1.3	0.5	
5 DR ORD-CONFUS-TIME	12	19	5	3	39
	30.8	48.7	12.8	7.7	10.5
	16.9	11.9	6.9	4.4	
	3.2	5.1	1.3	0.8	
6 DR ORD-MISS ORDERS	11	11	1	1	24
	45.8	45.8	4.2	4.2	6.5
	15.5	6.9	1.4	1.5	
	3.0	3.0	0.3	0.3	
7 DR ORD-STIL TRANSC	0	1	0	1	2
	0.0	50.0	0.0	50.0	0.5
	0.0	0.6	0.0	1.5	
	0.0	0.3	0.0	0.3	
COLUMN TOTAL	71	160	72	68	371
	19.1	43.1	19.4	18.3	100.0

PERCENTS AND TOTALS BASED ON RESPONDENTS

(CONTINUED)

Table 101

CLINICAL NURSING RECORDS STUDY

GENERAL COMMENTS REGARDING THE TEST FORMS

BY TYPE OF PROVIDER (CONTINUED)

COMMENTS	COUNT / ROW PCT / COL PCT / TAB PCT	TYPE IRN 1	PARA 2	WARD CLERK 3	PROFESSIONAL 4	ROW TOTAL
8		6	7	6	3	22
DR ORD-MISC PROBLEM		27.3	31.8	27.3	13.6	5.9
		8.5	4.4	8.3	4.4	
		1.6	1.9	1.6	0.8	
9		8	30	17	4	59
DR ORD 1-SHEET PREFR		13.6	50.8	28.8	6.8	15.9
		11.3	18.8	23.6	5.9	
		2.2	8.1	4.6	1.1	
10		2	4	2	0	8
DR ORD REDISN COMMNT		25.0	50.0	25.0	0.0	2.2
		2.8	2.5	2.8	0.0	
		0.5	1.1	0.5	0.0	
11		18	27	14	18	77
509+ GEN SATISFACT		23.4	35.1	18.2	23.4	20.8
		25.4	16.9	19.4	26.5	
		4.9	7.3	3.8	4.9	
12		0	6	3	2	11
509+IMPROVES COMMUN		0.0	54.5	27.3	18.2	3.0
		0.0	3.8	4.2	2.9	
		0.0	1.6	0.8	0.5	
13		1	6	6	0	13
509+ KEEP		7.7	46.2	46.2	0.0	3.5
		1.4	3.8	8.3	0.0	
		0.3	1.6	1.6	0.0	
14		1	2	2	1	6
509- GEN PROBLEMS		16.7	33.3	33.3	16.7	1.6
		1.4	1.3	2.8	1.5	
		0.3	0.5	0.5	0.3	
COLUMN TOTAL		71	160	72	68	371
		19.1	43.1	19.4	18.3	100.0

Table 101

CLINICAL NURSING RECORDS STUDY

GENERAL COMMENTS REGARDING THE TEST FORMS

BY TYPE OF PROVIDER (CONTINUED)

COMMENTS	COUNT / ROW PCT / COL PCT / TAB PCT	TYPE IRN (1)	PARA (2)	WARD CLERK (3)	PROFESSIONAL (4)	ROW TOTAL
509-PARAPROF ENTRY	15	2	6	0	0	8
		25.0	75.0	0.0	0.0	2.2
		2.8	3.8	0.0	0.0	
		0.5	1.6	0.0	0.0	
509-DECR DOCU,LEGAL	16	2	5	4	5	16
		12.5	31.3	25.0	31.3	4.3
		2.8	3.1	5.6	7.4	
		0.5	1.3	1.1	1.3	
509-MDS DONT LIKE	17	1	2	0	1	4
		25.0	50.0	0.0	25.0	1.1
		1.4	1.3	0.0	1.5	
		0.3	0.5	0.0	0.3	
509-OUT OF SEQUENCE	18	2	0	0	0	2
		100.0	0.0	0.0	0.0	0.5
		2.8	0.0	0.0	0.0	
		0.5	0.0	0.0	0.0	
509-CONFUS,FRAGMNT	19	2	3	0	1	6
		33.3	50.0	0.0	16.7	1.6
		2.8	1.9	0.0	1.5	
		0.5	0.8	0.0	0.3	
509-NOTES QUALITY	20	6	9	3	3	21
		28.6	42.9	14.3	14.3	5.7
		8.5	5.6	4.2	4.4	
		1.6	2.4	0.8	0.8	
509-ID OF SOURCE	21	1	2	0	1	4
		25.0	50.0	0.0	25.0	1.1
		1.4	1.3	0.0	1.5	
		0.3	0.5	0.0	0.3	
	COLUMN TOTAL	71	160	72	68	371
		19.1	43.1	19.4	18.3	100.0

Table 101

CLINICAL NURSING RECORDS STUDY

GENERAL COMMENTS REGARDING THE TEST FORMS

BY TYPE OF PROVIDER (CONTINUED)

COMMENTS	COUNT / ROW PCT / COL PCT / TAB PCT	TYPE IRN 1	PARA 2	WARD CLERK 3	PROFES-SIONAL 4	ROW TOTAL
509 GO BACK TO SEP N	22	1	8	5	3	17
		5.9	47.1	29.4	17.6	4.6
		1.4	5.0	6.9	4.4	
		0.3	2.2	1.3	0.8	
3888-2 *GEN COMMENT	24	11	23	11	6	51
		21.6	45.1	21.6	11.8	13.7
		15.5	14.4	15.3	8.8	
		3.0	6.2	3.0	1.6	
3888-2-OLD BETTER	25	2	1	3	2	8
		25.0	12.5	37.5	25.0	2.2
		2.8	0.6	4.2	2.9	
		0.5	0.3	0.8	0.5	
3888-2 REDESIGN CMTS	26	10	22	8	12	52
		19.2	42.3	15.4	23.1	14.0
		14.1	13.8	11.1	17.6	
		2.7	5.9	2.2	3.2	
3888-2 OVERPRINT CMT	27	0	1	0	0	1
		0.0	100.0	0.0	0.0	0.3
		0.0	0.6	0.0	0.0	
		0.0	0.3	0.0	0.0	
3888-2 SPECIFIC PROB	28	4	3	0	0	7
		57.1	42.9	0.0	0.0	1.9
		5.6	1.9	0.0	0.0	
		1.1	0.8	0.0	0.0	
3888-3 + COMMENTS	29	15	22	11	10	58
		25.9	37.9	19.0	17.2	15.6
		21.1	13.8	15.3	14.7	
		4.0	5.9	3.0	2.7	
	COLUMN TOTAL	71	160	72	68	371
		19.1	43.1	19.4	18.3	100.0

Table 101

CLINICAL NURSING RECORDS STUDY

GENERAL COMMENTS REGARDING THE TEST FORMS

BY TYPE OF PROVIDER (CONTINUED)

COMMENTS	COUNT / ROW PCT / COL PCT / TAB PCT	TYPE IRN (1)	PARA (2)	WARD CLERK (3)	PROFESSIONAL (4)	ROW TOTAL
3888-3-NEVER USE	30	4	11	3	3	21
		19.0	52.4	14.3	14.3	5.7
		5.6	6.9	4.2	4.4	
		1.1	3.0	0.8	0.8	
3888-4+ COMMENTS	31	14	24	11	10	59
		23.7	40.7	18.6	16.9	15.9
		19.7	15.0	15.3	14.7	
		3.8	6.5	3.0	2.7	
3888-4-OLD BETTER	32	0	0	2	1	3
		0.0	0.0	66.7	33.3	0.8
		0.0	0.0	2.8	1.5	
		0.0	0.0	0.5	0.3	
3888-4 REDESIGN CMTS	33	3	4	0	4	11
		27.3	36.4	0.0	36.4	3.0
		4.2	2.5	0.0	5.9	
		0.8	1.1	0.0	1.1	
3888-4 MISC COMMENTS	34	1	2	0	0	3
		33.3	66.7	0.0	0.0	0.8
		1.4	1.3	0.0	0.0	
		0.3	0.5	0.0	0.0	
3888-5+ KEEP	35	11	27	12	15	65
		16.9	41.5	18.5	23.1	17.5
		15.5	16.9	16.7	22.1	
		3.0	7.3	3.2	4.0	
3888-5+REDESIGN CMT	36	5	6	6	11	28
		17.9	21.4	21.4	39.3	7.5
		7.0	3.8	8.3	16.2	
		1.3	1.6	1.6	3.0	
	COLUMN TOTAL	71	160	72	68	371
		19.1	43.1	19.4	18.3	100.0

Table 101

CLINICAL NURSING RECORDS STUDY

GENERAL COMMENTS REGARDING THE TEST FORMS

BY TYPE OF PROVIDER (CONTINUED)

COMMENTS	COUNT / ROW PCT / COL PCT / TAB PCT	TYPE: IRN (1)	PARA (2)	WARD CLERK (3)	PROFESSIONAL (4)	ROW TOTAL
3888-5+MULTIDISCIP	37	0	6	0	1	7
		0.0	85.7	0.0	14.3	1.9
		0.0	3.8	0.0	1.5	
		0.0	1.6	0.0	0.3	
3888-5-DEDUNDANT	38	1	6	2	0	9
		11.1	66.7	22.2	0.0	2.4
		1.4	3.8	2.8	0.0	
		0.3	1.6	0.5	0.0	
3888-5 MIS COMMENTS	39	1	2	0	1	4
		25.0	50.0	0.0	25.0	1.1
		1.4	1.3	0.0	1.5	
		0.3	0.5	0.0	0.3	
TDS+KEEP,NO CHANGES	40	13	21	11	4	49
		26.5	42.9	22.4	8.2	13.2
		18.3	13.1	15.3	5.9	
		3.5	5.7	3.0	1.1	
TDS REDESIGN COMMNTS	41	12	23	8	16	59
		20.3	39.0	13.6	27.1	15.9
		16.9	14.4	11.1	23.5	
		3.2	6.2	2.2	4.3	
TDS CODING ISSUES	42	1	4	6	1	12
		8.3	33.3	50.0	8.3	3.2
		1.4	2.5	8.3	1.5	
		0.3	1.1	1.6	0.3	
TDS-OLD BETTER	43	3	8	4	2	17
		17.6	47.1	23.5	11.8	4.6
		4.2	5.0	5.6	2.9	
		0.8	2.2	1.1	0.5	
COLUMN TOTAL		71	160	72	68	371
		19.1	43.1	19.4	18.3	100.0

Table 101

CLINICAL NURSING RECORDS STUDY

GENERAL COMMENTS REGARDING THE TEST FORMS

BY TYPE OF PROVIDER (CONTINUED)

COMMENTS	COUNT / ROW PCT / COL PCT / TAB PCT	TYPE IRN	PARA	WARD CLERK	PROFES-SIONAL	ROW TOTAL
		1	2	3	4	
TDS OVERPRINT COMMEN	44	11	2	2	3	18
		61.1	11.1	11.1	16.7	4.9
		15.5	1.3	2.8	4.4	
		3.0	0.5	0.5	0.8	
GEN+SYS CHG CMTS	45	11	21	8	11	51
		21.6	41.2	15.7	21.6	13.7
		15.5	13.1	11.1	16.2	
		3.0	5.7	2.2	3.0	
GEN -CMTS,OLD BETTR	46	2	6	8	2	18
		11.1	33.3	44.4	11.1	4.9
		2.8	3.8	11.1	2.9	
		0.5	1.6	2.2	0.5	
OVEPRINT COMMENTS	47	1	5	1	0	7
		14.3	71.4	14.3	0.0	1.9
		1.4	3.1	1.4	0.0	
		0.3	1.3	0.3	0.0	
REDESIGN COMMENTS	48	1	1	0	1	3
		33.3	33.3	0.0	33.3	0.8
		1.4	0.6	0.0	1.5	
		0.3	0.3	0.0	0.3	
SPECIFIC AREA PROBS	49	2	7	0	2	11
		18.2	63.6	0.0	18.2	3.0
		2.8	4.4	0.0	2.9	
		0.5	1.9	0.0	0.5	
TDS WANT YELLOW HL	50	4	21	4	19	48
		8.3	43.8	8.3	39.6	12.9
		5.6	13.1	5.6	27.9	
		1.1	5.7	1.1	5.1	
	COLUMN TOTAL	71	160	72	68	371
		19.1	43.1	19.4	18.3	100.0

PERCENTS AND TOTALS BASED ON RESPONDENTS

371 VALID CASES 471 MISSING CASES

Table 102

CLINICAL NURSING RECORDS STUDY

GENERAL COMMENTS REGARDING DA FORM 3888-2 TEST NURSING HISTORY AND ASSESSMENT BY TYPE OF PROVIDER

COMMENTS	COUNT / ROW PCT / COL PCT / TAB PCT	TYPE IRN (1)	PARA (2)	WARD CLERK (3)	PROFESSIONAL (4)	ROW TOTAL
3888-2 +GEN COMMENT	24	11	23	11	6	51
		21.6	45.1	21.6	11.8	42.9
		40.7	46.0	50.0	30.0	
		9.2	19.3	9.2	5.0	
3888-2-OLD BETTER	25	2	1	3	2	8
		25.0	12.5	37.5	25.0	6.7
		7.4	2.0	13.6	10.0	
		1.7	.8	2.5	1.7	
3888-2 REDESIGN CMTS	26	10	22	8	12	52
		19.2	42.3	15.4	23.1	43.7
		37.0	44.0	36.4	60.0	
		8.4	18.5	6.7	10.1	
3888-2 OVERPRINT CMT	27	0	1	0	0	1
		.0	100.0	.0	.0	.8
		.0	2.0	.0	.0	
		.0	.8	.0	.0	
3888-2 SPECIFIC PROB	28	4	3	0	0	7
		57.1	42.9	.0	.0	5.9
		14.8	6.0	.0	.0	
		3.4	2.5	.0	.0	
	COLUMN TOTAL	27	50	22	20	119
		22.7	42.0	18.5	16.8	100.0

PERCENTS AND TOTALS BASED ON RESPONDENTS

119 VALID CASES; 723 MISSING CASES

Table 103

CLINICAL NURSING RECORDS STUDY

GENERAL COMMENTS REGARDING DA FORM 3888-3 TEST

NURSING HISTORY AND ASSESSMENT CONTINUATION

BY TYPE OF PROVIDER

COMMENTS	COUNT / ROW PCT / COL PCT / TAB PCT	TYPE IRN 1	PARA 2	WARD CLERK 3	PROFESSIONAL 4	ROW TOTAL
3888-3 + COMMENTS	29	15	22	11	10	58
		25.9	37.9	19.0	17.2	74.4
		78.9	68.8	78.6	76.9	
		19.2	28.2	14.1	12.8	
3888-3-NEVER USE	30	4	11	3	3	21
		19.0	52.4	14.3	14.3	26.9
		21.1	34.4	21.4	23.1	
		5.1	14.1	3.8	3.8	
COLUMN TOTAL		19	32	14	13	78
		24.4	41.0	17.9	16.7	100.0

PERCENTS AND TOTALS BASED ON RESPONDENTS

78 VALID CASES; 764 MISSING CASES

Table 104

CLINICAL NURSING RECORDS STUDY

GENERAL COMMENTS REGARDING DA FORM 3888-4 TEST

NURSING CARE PLAN BY TYPE OF PROVIDER

COMMENTS	TYPE: RN (1)	PARA (2)	WARD CLERK (3)	PROFESSIONAL (4)	ROW TOTAL
3888-4+ COMMENTS	14	24	11	10	59
	23.7	40.7	18.6	16.9	77.6
	77.8	80.0	84.6	66.7	
	18.4	31.6	14.5	13.2	
3888-4-OLD BETTER	0	0	2	1	3
	.0	.0	66.7	33.3	3.9
	.0	.0	15.4	6.7	
	.0	.0	2.6	1.3	
3888-4 REDESIGN CMTS	3	4	0	4	11
	27.3	36.4	.0	36.4	14.5
	16.7	13.3	.0	26.7	
	3.9	5.3	.0	5.3	
3888-4 MISC COMMENTS	1	2	0	0	3
	33.3	66.7	.0	.0	3.9
	5.6	6.7	.0	.0	
	1.3	2.6	.0	.0	
COLUMN TOTAL	18	30	13	15	76
	23.7	39.5	17.1	19.7	100.0

PERCENTS AND TOTALS BASED ON RESPONDENTS

76 VALID CASES; 766 MISSING CASES

Table 105

CLINICAL NURSING RECORDS STUDY

GENERAL COMMENTS REGARDING DA FORM 3888-5 TEST

NURSING DISCHARGE SUMMARY

BY TYPE OF PROVIDER

COMMENTS	COUNT / ROW PCT / COL PCT / TAB PCT	TYPE IRN 1	PARA 2	WARD CLERK 3	PROFES-SIONAL 4	ROW TOTAL
3888-5+ KEEP	35	11	27	12	15	65
		16.9	41.5	18.5	23.1	60.2
		61.1	58.7	60.0	62.5	
		10.2	25.0	11.1	13.9	
3888-5+REDESIGN CMT	36	5	6	6	11	28
		17.9	21.4	21.4	39.3	25.9
		27.8	13.0	30.0	45.8	
		4.6	5.6	5.6	10.2	
3888-5+MULTIDISCIP	37	0	6	0	1	7
		.0	85.7	.0	14.3	6.5
		.0	13.0	.0	4.2	
		.0	5.6	.0	.9	
3888-5-DEDUNDANT	38	1	6	2	0	9
		11.1	66.7	22.2	.0	8.3
		5.6	13.0	10.0	.0	
		.9	5.6	1.9	.0	
3888-5 MIS COMMENTS	39	1	2	0	1	4
		25.0	50.0	.0	25.0	3.7
		5.6	4.3	.0	4.2	
		.9	1.9	.0	.9	
	COLUMN TOTAL	18	46	20	24	108
		16.7	42.6	18.5	22.2	100.0

PERCENTS AND TOTALS BASED ON RESPONDENTS

108 VALID CASES; 734 MISSING CASES

Table 106

CLINICAL NURSING RECORDS STUDY

GENERAL COMMENTS REGARDING DA FORM 4256-1 TEST DOCTOR'S ORDER SHEET MEDICATION AND DA FORM 4256-2 TEST DOCTOR'S ORDER SHEET NONMEDICATION

BY TYPE OF PROVIDER

COMMENTS	COUNT / ROW PCT / COL PCT / TAB PCT	TYPE IRN (1)	PARA (2)	WARD CLERK (3)	PROFES-SIONAL (4)	ROW TOTAL
1 DR ORDER +GEN SAT		13	28	11	11	63
		20.6	44.4	17.5	17.5	30.6
		31.0	28.6	20.8	44.0	
		6.3	13.6	5.3	5.3	
2 DR ORD +SINGLE ACT		1	6	0	3	10
		10.0	60.0	.0	30.0	4.9
		2.4	6.1	.0	12.0	
		.5	2.9	.0	1.5	
3 DR ORD+EASY REFER		0	7	2	0	9
		.0	77.8	22.2	.0	4.4
		.0	7.1	4.9	.0	
		.0	3.4	1.0	.0	
4 DR ORD-GEN-PAPERWRK		3	14	5	2	24
		12.5	58.3	20.8	8.3	11.7
		7.1	14.3	12.2	8.0	
		1.5	6.8	2.4	1.0	
5 DR ORD-CONFUS-TIME		12	19	5	3	39
		30.8	48.7	12.8	7.7	18.9
		28.6	19.4	12.2	12.0	
		5.8	9.2	2.4	1.5	
6 DR ORD-MISS ORDERS		11	11	1	1	24
		45.8	45.8	4.2	4.2	11.7
		26.2	11.2	2.4	4.0	
		5.3	5.3	.5	.5	
7 DR ORD-STIL TRANSC		0	1	0	1	2
		.0	50.0	.0	50.0	1.0
		.0	1.0	.0	4.0	
		.0	.5	.0	.5	
(CONTINUED)	COLUMN TOTAL	42	98	41	25	206
		20.4	47.6	19.9	12.1	100.0

Table 106

CLINICAL NURSING RECORDS STUDY

GENERAL COMMENTS REGARDING DA FORM 4256-1 TEST DOCTOR'S ORDER SHEET MEDICATION AND DA FORM 4256-2 TEST DOCTOR'S ORDER SHEET NONMEDICATION BY TYPE OF PROVIDER (CONTINUED)

COMMENTS	COUNT / ROW PCT / COL PCT / TAB PCT	TYPE IRN (1)	PARA (2)	WARD CLERK (3)	PROFESSIONAL (4)	ROW TOTAL
8 DR ORD-MISC PROBLEM		6	7	6	3	22
		27.3	31.8	27.3	13.6	10.7
		14.3	7.1	14.6	12.0	
		2.9	3.4	2.9	1.5	
9 DR ORD 1-SHEET PREFR		8	30	17	4	59
		13.6	50.8	28.8	6.8	28.6
		19.0	30.6	41.5	16.0	
		3.9	14.6	8.3	1.9	
10 DR ORD REDISN COMMNT		2	4	2	0	8
		25.0	50.0	25.0	.0	3.9
		4.8	4.1	4.9	.0	
		1.0	1.9	1.0	.0	
COLUMN TOTAL		42	98	41	25	206
		20.4	47.6	19.9	12.1	100.0

PERCENTS AND TOTALS BASED ON RESPONDENTS

206 VALID CASES; 636 MISSING CASES

Table 107

CLINICAL NURSING RECORDS STUDY

GENERAL COMMENTS REGARDING

DA FORM 4677-1 TEST THERAPEUTIC DOCUMENTATION CARE PLAN NONMEDICATION

AND DA FORM 4678-1 TEST THERAPEUTIC DOCUMENTATION CARE PLAN MEDICATION

BY TYPE OF PROVIDER

COMMENTS	COUNT / ROW PCT / COL PCT / TAB PCT	TYPE: IRN (1)	PARA (2)	WARD CLERK (3)	PROFESSIONAL (4)	ROW TOTAL
40 TDS+KEEP,NO CHANGES		13	21	11	4	49
		26.5	42.9	22.4	8.2	34.0
		37.1	37.5	39.3	16.0	
		9.0	14.6	7.6	2.8	
41 TDS REDESIGN COMMNTS		12	23	8	16	59
		20.3	39.0	13.6	27.1	41.0
		34.3	41.1	28.6	64.0	
		8.3	16.0	5.6	11.1	
42 TDS CODING ISSUES		1	4	5	1	12
		8.3	33.3	50.0	8.3	8.3
		2.9	7.1	21.4	4.0	
		.7	2.8	4.2	.7	
43 TDS-OLD BETTER		3	8	4	2	17
		17.6	47.1	23.5	11.8	11.8
		8.6	14.3	14.3	8.0	
		2.1	5.6	2.8	1.4	
44 TDS OVERPRINT COMMEN		11	2	2	3	18
		61.1	11.1	11.1	16.7	12.5
		31.4	3.6	7.1	12.0	
		7.6	1.4	1.4	2.1	
COLUMN TOTAL		35	56	28	25	144
		24.3	38.9	19.4	17.4	100.0

PERCENTS AND TOTALS BASED ON RESPONDENTS

144 VALID CASES; 698 MISSING CASES

Table 108

CLINICAL NURSING RECORDS STUDY

GENERAL COMMENTS REGARDING INTEGRATED PROGRESS NOTES

BY TYPE OF PROVIDER

COMMENTS	COUNT / ROW PCT / COL PCT / TAB PCT	TYPE: RN 1	PARA 2	WARD CLERK 3	PROFESSIONAL 4	ROW TOTAL
11		18	27	14	18	77
509+ GEN SATISFACT		23.4	35.1	18.2	23.4	49.7
		62.1	42.9	43.8	58.1	
		11.6	17.4	9.0	11.6	
12		0	6	3	2	11
509+IMPROVES COMMUN		.0	54.5	27.3	18.2	7.1
		.0	9.5	9.4	6.5	
		.0	3.9	1.9	1.3	
13		1	6	6	0	13
509+ KEEP		7.7	46.2	46.2	.0	8.4
		3.4	9.5	18.8	.0	
		.6	3.9	3.9	.0	
14		1	2	2	1	6
509- GEN PROBLEMS		16.7	33.3	33.3	16.7	3.9
		3.4	3.2	6.3	3.2	
		.6	1.3	1.3	.6	
15		2	6	0	0	8
509-PARAPROF ENTRY		25.0	75.0	.0	.0	5.2
		6.9	9.5	.0	.0	
		1.3	3.9	.0	.0	
16		2	5	4	5	16
509-DECR DOCU,LEGAL		12.5	31.3	25.0	31.3	10.3
		6.9	7.9	12.5	16.1	
		1.3	3.2	2.6	3.2	
17		1	2	0	1	4
509-MDS DONT LIKE		25.0	50.0	.0	25.0	2.6
		3.4	3.2	.0	3.2	
		.6	1.3	.0	.6	
(CONTINUED)	COLUMN TOTAL	29	63	32	31	155
		18.7	40.6	20.6	20.0	100.0

Table 108

CLINICAL NURSING RECORDS STUDY

GENERAL COMMENTS REGARDING INTEGRATED PROGRESS NOTES

BY TYPE OF PROVIDER (CONTINUED)

COMMENTS	COUNT / ROW PCT / COL PCT / TAB PCT	TYPE: IRN (1)	PARA (2)	WARD CLERK (3)	PROFESSIONAL (4)	ROW TOTAL
18		2	0	0	0	2
509-OUT OF SEQUENCE		100.0	.0	.0	.0	1.3
		6.9	.0	.0	.0	
		1.3	.0	.0	.0	
19		2	3	0	1	6
509-CONFUS,FRAGMNT		33.3	50.0	.0	16.7	3.9
		6.9	4.8	.0	3.2	
		1.3	1.9	.0	.6	
20		6	9	3	3	21
509-NOTES QUALITY		28.6	42.9	14.3	14.3	13.5
		20.7	14.3	9.4	9.7	
		3.9	5.8	1.9	1.9	
21		1	2	0	1	4
509-ID OF SOURCE		25.0	50.0	.0	25.0	2.6
		3.4	3.2	.0	3.2	
		.6	1.3	.0	.6	
22		1	8	5	3	17
509 CO PACK TO SEP N		5.9	47.1	29.4	17.6	11.0
		3.4	12.7	15.6	9.7	
		.6	5.2	3.2	1.9	
COLUMN TOTAL		29	63	32	31	155
		18.7	40.6	20.6	20.0	100.0

PERCENTS AND TOTALS BASED ON RESPONDENTS

155 VALID CASES; 687 MISSING CASES

Table 109

CLINICAL NURSING RECORDS STUDY

CURRENT DUTY ASSIGNMENT

BY TYPE OF PROVIDER

F1	TYPE IRNS 1	PARA 2	ROW TOTAL
1 CLIN STAFF NURSE	225 41.1		225 41.1
2 CLIN HEAD NURSE	44 8.0		44 8.0
3 CLIN NURSE SPEC	9 1.6		9 1.6
4 SPEC PRACTICES	20 3.6		20 3.6
5 SECT SUPV	2 .4		2 .4
6 CH-ASST CH NURSE	2 .4		2 .4
7 OTHER	1 .2		1 .2
8 91A-AIDE		46 8.4	46 8.4
9 91B		6 1.1	6 1.1
10 91C PRACT NRS		169 30.8	169 30.8
11 91F-PSYCH TECH		23 4.2	23 4.2
12 OTHER		1 .2	1 .2
COLUMN TOTAL	303 55.3	245 44.7	548 100.0

NUMBER OF MISSING OBSERVATIONS = 298

Table 110

CLINICAL NURSING RECORDS STUDY

"ARE YOU A WARDMASTER?"

BY TYPE OF PROVIDER

		TYPE	
	COUNT	PARA	ROW TOTAL
		2	
WARDMASTER	1	36	36
YES			15.1
	2	202	202
NO			84.9
	COLUMN TOTAL	238	238
		100.0	100.0

NUMBER OF MISSING OBSERVATIONS = 606

Table 111

CLINICAL NURSING RECORDS STUDY

PRIMARY INPATIENT NURSING UNIT

BY TYPE OF PROVIDER

H3	TYPE COUNT I IRNS 1	FAFA 2	HARD CLERK 3	ROW TOTAL
0	4			4
DOES NOT APPLY				.7
1	72	50	8	130
SURG UNIT				22.1
2	18	29	2	49
PSYCH UNIT				8.3
3	33	33	5	71
MED UNIT				12.1
4	11	25	4	40
COMBINED MED SUR				6.8
5	18	21	3	42
PEDS UNIT				7.1
6	59	43	4	106
ALL ICU S				18.0
7	60	40	7	107
LBD NBN POST PAR				18.2
8	27			27
CF ANES				4.6
9	7	5	1	13
OTHER				2.2
COLUMN TOTAL	309 52.5	246 41.8	34 5.8	589 100.0

NUMBER OF MISSING OBSERVATIONS = 257

Table 112

CLINICAL NURSING RECORDS STUDY

NUMBER OF YEARS WORKED AS A REGISTERED NURSE

BY TYPE OF PROVIDER

H4	TYPE I IRNS I I		ROW TOTAL
COUNT	I	II	
0	8		8
			2.7
1	35		35
			11.7
2	48		48
			16.0
3	13		13
			4.3
4	11		11
			3.7
5	12		12
			4.0
6	14		14
			4.7
7	12		12
			4.0
8	17		17
			5.7
9	6		6
			2.0
10	12		12
			4.0
11	11		11
			3.7
12	14		14
			4.7
13	13		13
			4.3
14	6		6
			2.0
15	11		11
			3.7
16	9		9
			3.0
17	5		5
			1.7
18	4		4
			1.3
19	2		2
			.7
20	13		13
			4.3
21	1		1
			.3
23	2		2
			.7
24	3		3
			1.0
25	2		2
			.7
26	2		2
			.7
28	2		2
			.7
29	1		1
			.3
30	6		6
			2.0
32	1		1
			.3
33	1		1
			.3
34	1		1
			.3
36	1		1
			.3
39	1		1
			.3
COLUMN TOTAL	300		300
	100.0		100.0

NUMBER OF MISSING OBSERVATIONS = 546

Table 113

CLINICAL NURSING RECORDS STUDY

CORPS AFFILIATION BY

TYPE OF PROVIDER

		TYPE	
	COUNT	PROFESSIONAL	ROW TOTAL
		4	
HS	0	2	2
			.9
	1	26	26
AMSC-CIV			11.8
	2	1	1
PC-CIV			.5
	3	186	186
MC-CIV			84.2
	4	4	4
NSC-CIV			1.8
	5	2	2
VC-PA			.9
	COLUMN TOTAL	221	221
		100.0	100.0

NUMBER OF MISSING OBSERVATIONS = 625

Table 114

CLINICAL NURSING RECORDS STUDY

NUMBER OF YEARS WORKED WITH ARMY INPATIENT

MEDICAL RECORDS/DOCUMENTATION

BY TYPE OF PROVIDER

H6 COUNT	TYPE: IRNS (1)	PAPA (2)	WARD CLERK (3)	PROFESSIONAL (4)	ROW TOTAL
0	23	28	1	24	76
					9.6
1	65	34	3	19	121
					15.3
2	63	49	13	29	154
					19.5
3	17	12	1	20	50
					6.3
4	12	11	4	18	45
					5.7
5	8	10	5	9	32
					4.0
6	11	15		16	42
					5.3
7	6	6		18	30
					3.8
8	11	11		12	34
					4.3
9	7	4		9	20
					2.5
10	14	13	5	10	42
					5.3
11	2	4		5	11
					1.4
12	12	5		10	27
					3.4
13	5	4	1	2	12
					1.5
14	6	5		3	14
					1.8
15	9	5		6	20
					2.5
16	4	2		1	7
					.9
17	4		1	2	6
					.8
18	7	3		4	14
					1.8
19	1	1		3	5
					.6
20	4	7		2	13
					1.6
21	2	1			3
					.4
22		2			2
					.3
23	1				1
					.1
24	1			2	3
					.4
25				1	1
					.1
26	1				1
					.1
27	1				1
					.1
28	1				1
					.1
30	1	1			2
					.3
35		1			1
					.1
COLUMN TOTAL	299	234	33	225	791
	37.8	29.6	4.2	28.4	100.0

NUMBER OF MISSING OBSERVATIONS = 55

Table 115

CLINICAL NURSING RECORDS STUDY

FINAL GENERAL COMMENTS

BY TYPE OF PROVIDER

COMMENTS	COUNT / ROW PCT / COL PCT / TAB PCT	TYPE IRN (1)	PARA (2)	WARD CLERK (3)	PROFES-SIONAL (4)	ROW TOTAL
GEN+SYS CHG CMTS	45	11	21	8	11	51
		21.6	41.2	15.7	21.6	42.1
		61.1	40.4	40.0	35.5	
		9.1	17.4	6.6	9.1	
GEN -CMTS,OLD BETTR	46	2	6	8	2	18
		11.1	33.3	44.4	11.1	14.9
		11.1	11.5	40.0	6.5	
		1.7	5.0	6.6	1.7	
OVEPRINT COMMENTS	47	1	5	1	0	7
		14.3	71.4	14.3	.0	5.8
		5.6	9.6	5.0	.0	
		.8	4.1	.8	.0	
REDESIGN COMMENTS	48	1	1	0	1	3
		33.3	33.3	.0	33.3	2.5
		5.6	1.9	.0	3.2	
		.8	.8	.0	.8	
SPECIFIC AREA PROBS	49	2	7	0	2	11
		18.2	63.6	.0	18.2	9.1
		11.1	13.5	.0	6.5	
		1.7	5.8	.0	1.7	
TOS WANT YELLOW HL	50	4	21	4	19	48
		8.3	43.8	8.3	39.6	39.7
		22.2	40.4	20.0	61.3	
		3.3	17.4	3.3	15.7	
COLUMN TOTAL		18	52	20	31	121
		14.9	43.0	16.5	25.6	100.0

PERCENTS AND TOTALS BASED ON RESPONDENTS

121 VALID CASES; 721 MISSING CASES

APPENDIX J

CNR Study Test Site Personnel Survey Responses

Fort Campbell, Kentucky

Table 1

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

TYPE OF RESPONDENT

VALUE LABEL	VALUE	FREQUENCY	PERCENT	VALID PERCENT	CUM PERCENT
RNS	1	52	39.1	39.1	39.1
PARA	2	54	40.6	40.6	79.7
WARD CLERK	3	7	5.3	5.3	85.0
PROFES- SIONAL	4	20	15.0	15.0	100.0
	TOTAL	133	100.0	100.0	

VALID CASES 133 MISSING CASES 0

Table 2

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

"COMPARED TO THE OLD SYSTEM, I FEEL THE TEST FORMS SAVE ME NURSING DOCUMENTATION TIME" BY TYPE OF PROVIDER

A1 / COUNT	TYPE: RNS (1)	PARA (2)	ROW TOTAL
1 STRONGLY AGREE	28	15	43
			42.2
2 AGREE	18	31	49
			48.0
3 DISAGREE	3	4	7
			6.9
4 STRONGLY DISAGRE	1	2	3
			2.9
COLUMN TOTAL	50	52	102
	49.0	51.0	100.0

NUMBER OF MISSING OBSERVATIONS = 31

Table 3

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

"COMPARED TO THE OLD SYSTEM, I FEEL THE TEST FORMS HELP AVOID WRITING SAME INFORMATION SEVERAL PLACES"

BY TYPE OF PROVIDER

A2	TYPE: 1 IRNS	11 PARA	21 WARD CLERK	31	ROW TOTAL
1 STRONGLY AGREE	28	15	1		44
					40.4
2 AGREE	18	32	5		55
					50.5
3 DISAGREE	4	4	1		9
					8.3
4 STRONGLY DISAGRE		1			1
					.9
COLUMN TOTAL	50	52	7		109
	45.9	47.7	6.4		100.0

NUMBER OF MISSING OBSERVATIONS = 24

Table 4

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

"COMPARED TO THE OLD SYSTEM, I FEEL THE TEST FORMS IMPROVE COMMUNICATIONS ABOUT THE PATIENT AMONG NURSING PERSONNEL"

BY TYPE OF PROVIDER

A3	COUNT	TYPE IRNS 1	PARA 2	ROW TOTAL
STRONGLY AGREE	1	14	10	24
				23.5
AGREE	2	31	27	58
				56.9
DISAGREE	3	4	13	17
				16.7
STRONGLY DISAGREE	4	1	2	3
				2.9
	COLUMN TOTAL	50	52	102
		49.0	51.0	100.0

NUMBER OF MISSING OBSERVATIONS = 31

Table 5

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

"COMPARED TO THE OLD SYSTEM, I FEEL THE TEST FORMS IMPROVE COMMUNICATIONS ABOUT THE PATIENT BETWEEN NURSING AND OTHER HEALTH CARE PROFESSIONALS"

BY TYPE OF PROVIDER

A4	COUNT	TYPE RNS (1)	PARA (2)	ROW TOTAL
STRONGLY AGREE	1	14	11	25
				24.5
AGREE	2	30	31	61
				59.8
DISAGREE	3	4	10	14
				13.7
STRONGLY DISAGRE	4	2		2
				2.0
	COLUMN TOTAL	50 49.0	52 51.0	102 100.0

NUMBER OF MISSING OBSERVATIONS = 31

Table 6

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

"COMPARED TO THE OLD SYSTEM, I FEEL THE TEST FORMS ENCOURAGE ME TO USE THE NURSING PROCESS"

BY TYPE OF PROVIDER

A5	COUNT	TYPE IRNS II	ROW TOTAL
STRONGLY AGREE	1	17	17 34.7
AGREE	2	22	22 44.9
DISAGREE	3	10	10 20.4
	COLUMN TOTAL	49 100.0	49 100.0

NUMBER OF MISSING OBSERVATIONS = 84

Table 7

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

"COMPARED TO THE OLD SYSTEM, I FEEL THE TEST FORMS

ARE EASIER TO USE"

BY TYPE OF PROVIDER

A6	COUNT	TYPE 1 IRNS 1	2 PARA	3 WARD CLERK	ROW TOTAL
1 STRONGLY AGREE		23	15	1	39
					35.8
2 AGREE		24	30	5	59
					54.1
3 DISAGREE		4	6	1	11
					10.1
	COLUMN TOTAL	51	51	7	109
		46.8	46.8	6.4	100.0

NUMBER OF MISSING OBSERVATIONS = 24

Table 8

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

"COMPARED TO THE OLD SYSTEM, I FEEL THE TEST FORMS SHOULD HAVE BEEN A MORE DRASTIC CHANGE"

BY TYPE OF PROVIDER

A7	COUNT / TYPE	IRNS (1)	PARA (2)	WARD CLERK (3)	ROW TOTAL
1	STRONGLY AGREE	3	7		10
					9.4
2	AGREE	9	16	2	27
					25.5
3	DISAGREE	30	23	5	58
					54.7
4	STRONGLY DISAGRE	8	3		11
					10.4
	COLUMN TOTAL	50	49	7	106
		47.2	46.2	6.6	100.0

NUMBER OF MISSING OBSERVATIONS = 27

Table 9

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

"COMPARED TO THE OLD SYSTEM, I FEEL THE TEST FORMS

ARE A DEFINITE IMPROVEMENT"

BY TYPE OF PROVIDER

AB	TYPE: IRNS (1)	PARA (11)	WARD CLERK (21)	RDN (31)	ROW TOTAL
1 STRONGLY AGREE	23	11	2		36
					33.0
2 AGREE	26	34	4		64
					58.7
3 DISAGREE	1	6	1		8
					7.3
4 STRONGLY DISAGRE	1				1
					.9
COLUMN TOTAL	51	51	7		109
	46.8	46.8	6.4		100.0

NUMBER OF MISSING OBSERVATIONS = 24

Table 10

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

"COMPARED TO THE OLD SYSTEM, I FEEL THE TEST FORMS PROVIDE ME A BETTER PICTURE OF WHAT IS HAPPENING TO THE PATIENT"

BY TYPE OF PROVIDER

A9	COUNT	TYPE 1 IRNS	TYPE 11 PARA	TYPE 21	ROW TOTAL
STRONGLY AGREE	1	11	10		21
					20.6
AGREE	2	31	33		64
					62.7
DISAGREE	3	9	8		17
					16.7
	COLUMN TOTAL	51	51		102
		50.0	50.0		100.0

NUMBER OF MISSING OBSERVATIONS = 31

Table 11

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

"COMPARED TO THE OLD SYSTEM, I FEEL THE TEST FORMS

REDUCE THE AMOUNT OF PAPERWORK I HAVE TO DO"

BY TYPE OF PROVIDER

A10	TYPE COUNT	1 IRNS	PARA	2 WARD CLERK	3	ROW TOTAL
1	STRONGLY AGREE	20	15	2		37 33.9
2	AGREE	17	20	1		38 34.9
3	DISAGREE	10	13	4		27 24.8
4	STRONGLY DISAGRE	4	3			7 6.4
	COLUMN TOTAL	51 46.8	51 46.8	7 6.4		109 100.0

NUMBER OF MISSING OBSERVATIONS = 24

Table 12

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

"COMPARED TO THE OLD SYSTEM, I FEEL THE TEST FORMS HAVE IMPROVED THE QUALITY OF DOCUMENTATION ON MY NURSING UNIT"

BY TYPE OF PROVIDER

	TYPE		
COUNT	IRNS	PARA	ROW TOTAL
	1	2	
All			
1 STRONGLY AGREE	16	10	26 25.5
2 AGREE	26	28	54 52.9
3 DISAGREE	9	11	20 19.6
4 STRONGLY DISAGRE		2	2 2.0
COLUMN TOTAL	51 50.0	51 50.0	102 100.0

NUMBER OF MISSING OBSERVATIONS = 31

Table 13

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

"THE NUMBER OF NURSING HISTORY QUESTIONS IS ADEQUATE"

BY TYPE OF PROVIDER

B1	COUNT	TYPE IRNS (1)	TYPE PARA (2)	ROW TOTAL
1 STRONGLY AGREE		18	5	23
				24.5
2 AGREE		21	37	58
				61.7
3 DISAGREE		4	6	10
				10.6
4 STRONGLY DISAGRE		2	1	3
				3.2
	COLUMN TOTAL	45	49	94
		47.9	52.1	100.0

NUMBER OF MISSING OBSERVATIONS = 39

Table 14

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

"THE CONTENT OF THE NURSING HISTORY QUESTIONS IS AS THOROUGH AS I NEED THEM TO BE"

BY TYPE OF PROVIDER

B2	COUNT	TYPE IRNS 1	TYPE PARA 2	ROW TOTAL
1 STRONGLY AGREE		15	3	18
		19.1		
2 AGREE		23	37	60
		53.8		
3 DISAGREE		4	7	11
		11.7		
4 STRONGLY DISAGRE		3	2	5
		5.3		
COLUMN TOTAL		45	49	94
		47.9	52.1	100.0

NUMBER OF MISSING OBSERVATIONS = 39

Table 15

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

"ON MY NURSING UNIT THE BLOCK FOR PATIENT'S PERSONAL ARTICLES AND VALUABLES IS HELPFUL"

BY TYPE OF PROVIDER

B3	TYPE: IRNS (1)	PARA (2)	WARD CLERK (3)	ROW TOTAL
1 STRONGLY AGREE	8	8		16
	16.8			
2 AGREE	21	22	4	47
				49.5
3 DISAGREE	11	11	2	24
				25.3
4 STRONGLY DISAGREE	3	5		8
				8.4
COLUMN TOTAL	43	46	6	95
	45.3	48.4	6.3	100.0

NUMBER OF MISSING OBSERVATIONS = 38

Table 16

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

"ON MY NURSING UNIT MOST NURSING HISTORIES ARE

DONE BY NON-RN/ANC PERSONNEL."

BY TYPE OF PROVIDER

B4	COUNT	TYPE IRNS 1	PARA 2	WARD CLERK 3	ROW TOTAL
1		7	5	1	13
STRONGLY AGREE					12.5
2		17	21	3	41
AGREE					39.4
3		9	21	3	33
DISAGREE					31.7
4		13	4		17
STRONGLY DISAGREE					16.3
	COLUMN TOTAL	46 44.2	51 49.0	7 6.7	104 100.0

NUMBER OF MISSING OBSERVATIONS = 29

Table 17

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

"ON MY NURSING UNIT ALL NURSING ASSESSMENTS ARE

DONE BY RNs AND ANCs"

BY TYPE OF PROVIDER

B5	TYPE COUNT	RNS 1	PARA 11	WARD CLERK 21	 31	ROW TOTAL
STRONGLY AGREE	1	29	13	2		44
						41.9
AGREE	2	9	18	4		31
						29.5
DISAGREE	3	7	19			26
						24.8
STRONGLY DISAGRE	4	1	2	1		4
						3.8
	COLUMN TOTAL	46 43.8	52 49.5	7 6.7		105 100.0

NUMBER OF MISSING OBSERVATIONS = 28

Table 18

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

"ON MY NURSING UNIT AN OVERPRINT IS USED FOR

THE ASSESSMENT"

BY TYPE OF PROVIDER

B6	COUNT	TYPE RNS	ROW TOTAL
STRONGLY AGREE	1	12	12 26.1
AGREE	2	11	11 23.9
DISAGREE	3	12	12 26.1
STRONGLY DISAGREE	4	11	11 23.9
	COLUMN TOTAL	46 100.0	46 100.0

NUMBER OF MISSING OBSERVATIONS = 87

Table 19

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

"ON MY NURSING UNIT WE OFTEN USE THE HISTORY

AND ASSESSMENT CONTINUATION SHEET"

BY TYPE OF PROVIDER

B7	TYPE COUNT	1 RNS	PARA	3 WARD CLERK	ROW TOTAL
1 STRONGLY AGREE		8	9	1	17 17.2
2 AGREE		10	29	2	41 41.4
3 DISAGREE		14	11	1	26 26.3
4 STRONGLY DISAGREE		11	1	3	15 15.2
	COLUMN TOTAL	43 43.4	49 49.5	7 7.1	99 100.0

NUMBER OF MISSING OBSERVATIONS = 34

Table 20

FORT CAMPBELL

CLINIC NURSING RECORDS STUDY

"OVERPRINTING THE ASSESSMENT CATEGORIES FROM THE

STANDARDS OF NURSING PRACTICE (DA PAM 40-5)

IS HELPFUL TO ME"

BY TYPE OF PROVIDER

BB	TYPE COUNT RNS	ROW TOTAL
1 STRONGLY AGREE	17 42.5	17 42.5
2 AGREE	19 47.5	19 47.5
3 DISAGREE	2 5.0	2 5.0
4 STRONGLY DISAGREE	2 5.0	2 5.0
COLUMN TOTAL	40 100.0	40 100.0

NUMBER OF MISSING OBSERVATIONS = 93

Table 21

FORT CAMPBELL

CLINIC NURSING RECORDS STUDY

"OVERPRINTING THE ASSESSMENT CATEGORIES FROM THE STANDARDS OF NURSING PRACTICE (DA PAM 40-5) HAS INCREASED MY USE OF THE CATEGORIES"

BY TYPE OF PROVIDER

B9	COUNT	TYPE IRNS 11	ROW TOTAL
STRONGLY AGREE	1	13	13
		33.3	
AGREE	2	19	19
		48.7	
DISAGREE	3	5	5
		12.8	
STRONGLY DISAGRE	4	2	2
		5.1	
	COLUMN TOTAL	39 100.0	39 100.0

NUMBER OF MISSING OBSERVATIONS = 94

Table 22

FORT CAMPBELL

CLINIC NURSING RECORDS STUDY

"OVERPRINTING THE ASSESSMENT CATEGORIES FROM THE

STANDARDS OF NURSING PRACTICE (DA PAM 40-5)

SHOULD BE CONTINUED"

BY TYPE OF PROVIDER

		TYPE	
	COUNT	IRNS	ROW TOTAL
		11	
B10			
1	1	16	16
STRONGLY AGREE			41.0
2		21	21
AGREE			53.8
3		2	2
DISAGREE			5.1
	COLUMN TOTAL	39	39
		100.0	100.0

NUMBER OF MISSING OBSERVATIONS = 94

Table 23

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

"I LIKE THE IDEA OF THE NURSING HISTORY AND ASSESSMENT,

IF COMPLETED ON ADMISSION, SERVING AS THE ADMISSION

NURSING NOTE"

BY TYPE OF PROVIDER

B11	COUNT	TYPE IRNS 11	ROW TOTAL
STRONGLY AGREE	1	35	35
			77.8
AGREE	2	9	9
			20.0
STRONGLY DISAGRE	4	1	1
			2.2
	COLUMN TOTAL	45 100.0	45 100.0

NUMBER OF MISSING OBSERVATIONS = 88

Table 24

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

"OVERPRINTING THE NURSING DIAGNOSES ONTO THE CARE PLAN

IS HELPFUL TO ME"

BY TYPE OF PROVIDER

B12	COUNT	TYPE IRNS 1	ROW TOTAL
STRONGLY AGREE	1	23 50.0	23
AGREE	2	16 34.8	16
DISAGREE	3	6 13.0	6
STRONGLY DISAGREE	4	1 2.2	1
	COLUMN TOTAL	46 100.0	46 100.0

NUMBER OF MISSING OBSERVATIONS = 87

Table 25

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

"OVERPRINTING THE NURSING DIAGNOSES ONTO THE CARE PLAN HAS INCREASED MY USE OF THE DIAGNOSES"

BY TYPE OF PROVIDER

B13	COUNT / TYPE: IRNS (11)	ROW TOTAL
1 STRONGLY AGREE	19	19
		44.2
2 AGREE	18	18
		41.9
3 DISAGREE	5	5
		11.6
4 STRONGLY DISAGRE	1	1
		2.3
COLUMN TOTAL	43	43
	100.0	100.0

NUMBER OF MISSING OBSERVATIONS = 90

Table 26

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

"OVERPRINTING THE NURSING DIAGNOSES ONTO THE CARE PLAN SHOULD BE CONTINUED"

BY TYPE OF PROVIDER

B14	COUNT	TYPE IRNS 11	ROW TOTAL
1 STRONGLY AGREE		21	21
			46.7
2 AGREE		18	18
			40.0
3 DISAGREE		6	6
			13.3
	COLUMN TOTAL	45	45
		100.0	100.0

NUMBER OF MISSING OBSERVATIONS = 88

Table 27

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

"I READ THE NURSING CARE PLAN TO LEARN THE OVERALL GOALS FOR THE PATIENT"

BY TYPE OF PROVIDER

B15	COUNT	TYPE 1 PARA 21	ROW TOTAL
STRONGLY AGREE	1	11	11 21.2
AGREE	2	36	36 69.2
DISAGREE	3	5	5 9.5
	COLUMN TOTAL	52 100.0	52 100.0

NUMBER OF MISSING OBSERVATIONS = 81

Table 28

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

"OTHER THAN THE PATIENT IDENTIFICATION STAMP, I HAVE COMPLETED SOME PORTIONS OF THE NURSING DISCHARGE SUMMARY FOR THE NURSES"

BY TYPE OF PROVIDER

C1	COUNT / TYPE	PARA (2)	WARD CLERK (3)	ROW TOTAL
1 STRONGLY AGREE		9	1	10
				17.5
2 AGREE		24	4	28
				49.1
3 DISAGREE		14	1	15
				26.3
4 STRONGLY DISAGRE		3	1	4
				7.0
	COLUMN TOTAL	50	7	57
		87.7	12.3	100.0

NUMBER OF MISSING OBSERVATIONS = 76

Table 29

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

"OTHER THAN THE PATIENT IDENTIFICATION STAMP, THE ENTIRE NURSING DISCHARGE SUMMARY IS COMPLETED ONLY BY AN RN/ANC ON MY NURSING UNIT"

BY TYPE OF PROVIDER

C2	COUNT	TYPE PARA 2	WARD CLERK 3	ROW TOTAL
STRONGLY AGREE	1	4	2	6
				10.5
AGREE	2	15	2	17
				29.8
DISAGREE	3	25	2	27
				47.4
STRONGLY DISAGRE	4	6	1	7
				12.3
	COLUMN TOTAL	50 87.7	7 12.3	57 100.0

NUMBER OF MISSING OBSERVATIONS = 76

Table 30

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

"NURSING DISCHARGE SUMMARY (DA FORM 3888-5 TEST) - ELEMENTS ON THE FORM ARE THOSE I WOULD INCLUDE IN A DISCHARGE NURSING NOTE"

BY TYPE OF PROVIDER

C3	COUNT	TYPE IRNS 11	ROW TOTAL
STRONGLY AGREE	1	20	20
		46.5	46.5
AGREE	2	20	20
		46.5	46.5
DISAGREE	3	2	2
		4.7	4.7
STRONGLY DISAGREE	4	1	1
		2.3	2.3
	COLUMN TOTAL	43	43
		100.0	100.0

NUMBER OF MISSING OBSERVATIONS = 90

Table 31

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

"NURSING DISCHARGE SUMMARY (DA FORM 3888-5 TEST) - I LIKE TO HAVE THE DISCHARGE SUMMARY SERVE AS THE NURSING DISCHARGE NOTE"

BY TYPE OF PROVIDER

C4	COUNT	TYPE IRNS	ROW TOTAL
STRONGLY AGREE	1	28	28
		65.1	65.1
AGREE	2	12	12
		27.9	27.9
DISAGREE	3	1	1
		2.3	2.3
STRONGLY DISAGRE	4	2	2
		4.7	4.7
	COLUMN TOTAL	43 100.0	43 100.0

NUMBER OF MISSING OBSERVATIONS = 90

Table 32

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

"NURSING DISCHARGE SUMMARY (DA FORM 3888-5 TEST) -

IT IS HELPFUL TO HAVE A COPY FOR THE PATIENT"

BY TYPE OF PROVIDER

C5	COUNT	TYPE 1RNS 11	ROW TOTAL
1 STRONGLY AGREE		23 53.5	23 53.5
2 AGREE		16 37.2	16 37.2
3 DISAGREE		2 4.7	2 4.7
4 STRONGLY DISAGRE		2 4.7	2 4.7
	COLUMN TOTAL	43 100.0	43 100.0

NUMBER OF MISSING OBSERVATIONS = 90

Table 33

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

"NURSING DISCHARGE SUMMARY (DA FORM 3888-5 TEST) - IT IS IMPORTANT FOR A NURSING SUMMARY TO APPEAR IN THE OUTPATIENT RECORD"

BY TYPE OF PROVIDER

C6	COUNT	TYPE IRNS	ROW TOTAL
1 STRONGLY AGREE		17	17
			38.6
2 AGREE		21	21
			47.7
3 DISAGREE		2	2
			4.5
4 STRONGLY DISAGRE		4	4
			9.1
	COLUMN TOTAL	44	44
		100.0	100.0

NUMBER OF MISSING OBSERVATIONS = 89

Table 34

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

"NURSING DISCHARGE SUMMARY (DA FORM 3888-5 TEST) - THE NURSING DISCHARGE SUMMARY FORM NEEDS TO BE KEPT IN THE SYSTEM"

BY TYPE OF PROVIDER

C7	COUNT / TYPE	IRNS	ROW TOTAL
1		21	21
STRONGLY AGREE			48.8
2		20	20
AGREE			46.5
3		1	1
DISAGREE			2.3
4		1	1
STRONGLY DISAGRE			2.3
COLUMN TOTAL		43	43
		100.0	100.0

NUMBER OF MISSING OBSERVATIONS = 90

Table 35

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

"NURSING DISCHARGE SUMMARY (DA FORM 3888-5 TEST) - DISCHARGE SUMMARIES SHOULD BE IN A MULTIDISCIPLINARY FORMAT SO PHYSICIANS AND OTHER HEALTH CARE PROVIDERS COULD MAKE APPROPRIATE NOTATIONS"

BY TYPE OF PROVIDER

CB	COUNT / TYPE: IRNS (1)	ROW TOTAL
1 STRONGLY AGREE	18	18
		40.9
2 AGREE	15	15
		34.1
3 DISAGREE	10	10
		22.7
4 STRONGLY DISAGRE	1	1
		2.3
COLUMN TOTAL	44	44
	100.0	100.0

NUMBER OF MISSING OBSERVATIONS = 89

Table 36

FORT CAMPBELL

CINICAL NURSING RECORDS STUDY

"DOCTOR'S ORDERS MEDICATION/DOCTOR'S ORDERS NONMEDICATION

(DA FORM 4256-1 TEST; DA FORM 4256-2 TEST) -

WE FREQUENTLY USE THE BUFF COPY ON

NURSING UNIT"

BY TYPE OF PROVIDER

D1	TYPE COUNT	IRNS 1	PARA 2	WARD CLERK 3	ROW TOTAL
1 STRONGLY AGREE	1	8	5		13
		13.0			13.0
2 AGREE	2	15	16	1	32
		32.0			32.0
3 DISAGREE	3	12	27	2	41
		41.0			41.0
4 STRONGLY DISAGRE	4	11	1	2	14
		14.0			14.0
	COLUMN TOTAL	46 46.0	49 49.0	5 5.0	100 100.0

NUMBER OF MISSING OBSERVATIONS = 33

Table 37

FORT CAMPBELL

CINICAL NURSING RECORDS STUDY

"DOCTOR'S ORDERS MEDICATION/DOCTOR'S ORDERS NONMEDICATION

(DA FORM 4256-1 TEST; DA FORM 4256-2 TEST) - I LIKE

NOT HAVING TO RECOPY SOME SINGLE ACTION ORDERS

ONTO THE THERAPEUTIC DOCUMENTATION CARE

PLAN"

BY TYPE OF PROVIDER

D2	COUNT	TYPE IRNS 1	PARA 2	WARD CLERK 3	ROW TOTAL
1		29	16	3	48
STRONGLY AGREE					47.1
2		10	26	3	39
AGREE					38.2
3		5	6		11
DISAGREE					10.8
4		2	2		4
STRONGLY DISAGRE					3.9
	COLUMN TOTAL	46 45.1	50 49.0	6 5.9	102 100.0

NUMBER OF MISSING OBSERVATIONS = 31

Table 38

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

"DURING THE TEST PERIOD, HOW OFTEN DID YOU USE THE NURSING HISTORY AND ASSESSMENT TO LEARN ABOUT NURSING ACTIVITIES AND THE PATIENT'S CONDITION?"

BY TYPE OF PROVIDER

X1A	COUNT / TYPE: PROFESSIONAL (4)	ROW TOTAL
1 EVERY PNT	1	1 / 5.0
2 MOST PNTS	5	5 / 25.0
3 RARELY	8	8 / 40.0
4 NEVER	6	6 / 30.0
COLUMN TOTAL	20 / 100.0	20 / 100.0

NUMBER OF MISSING OBSERVATIONS = 113

Table 39

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

"DURING THE TEST PERIOD, HOW OFTEN DID YOU USE THE NURSING CARE PLAN TO LEARN ABOUT NURSING ACTIVITY AND THE PATIENT'S CONDITION?"

BY TYPE OF PROVIDER

		TYPE	
	COUNT	PROFESSIONAL	ROW TOTAL
		4	
X18			
	2	3	3
MOST PNTS			15.0
	3	7	7
RARELY			35.0
	4	10	10
NEVER			50.0
	COLUMN TOTAL	20	20
		100.0	100.0

NUMBER OF MISSING OBSERVATIONS = 113

Table 40

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

"DURING THE TEST PERIOD, HOW OFTEN DID YOU USE THE NURSING DISCHARGE SUMMARY TO LEARN ABOUT NURSING ACTIVITIES AND THE PATIENT'S CONDITION?"

BY TYPE OF PROVIDER

X1C	COUNT	TYPE PROFESSIONAL 4	ROW TOTAL
1 EVERY PNT	1	1 5.0	1 5.0
2 MOST PNTS	2	3 15.0	3 15.0
3 RARELY	3	5 25.0	5 25.0
4 NEVER	4	11 55.0	11 55.0
	COLUMN TOTAL	20 100.0	20 100.0

NUMBER OF MISSING OBSERVATIONS = 113

Table 41

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

"DURING THE TEST PERIOD, HOW OFTEN DID YOU USE

THE THERAPEUTIC DOCUMENTATION CARE PLAN,

NONMEDICATION?"

BY TYPE OF PROVIDER

	TYPE	
COUNT	PROFESSIONAL	ROW TOTAL
	41	
XID		
1	1	1
EVERY PNT		5.0
2	5	5
MOST PNTS		25.0
3	5	5
RARELY		25.0
4	9	9
NEVER		45.0
COLUMN TOTAL	20	20
	100.0	100.0

NUMBER OF MISSING OBSERVATIONS = 113

Table 42

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

"DURING THE TEST PERIOD, HOW OFTEN DID YOU USE

THE THERAPEUTIC DOCUMENTATION CARE PLAN,

MEDICATION?"

BY TYPE OF PROVIDER

	TYPE	
COUNT	PROFESSIONAL	ROW TOTAL
X1E	4	
1 EVERY PNT	1	1
	5.0	5.0
2 MOST PNTS	6	6
	30.0	30.0
3 RARELY	5	5
	25.0	25.0
4 NEVER	8	8
	40.0	40.0
COLUMN TOTAL	20	20
	100.0	100.0

NUMBER OF MISSING OBSERVATIONS = 113

Table 43

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

"DURING THE TEST PERIOD, HOW OFTEN DID YOU USE THE TPR GRAPHIC?"

BY TYPE OF PROVIDER

X1F	COUNT	TYPE: PROFESSIONAL (4)	ROW TOTAL
1 EVERY PNT	1	11	11 55.0
2 MOST PNTS	2	5	5 25.0
3 RARELY	3	1	1 5.0
4 NEVER	4	3	3 15.0
	COLUMN TOTAL	20 100.0	20 100.0

NUMBER OF MISSING OBSERVATIONS = 113

Table 44

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

"DURING THE TEST PERIOD, HOW OFTEN DID YOU USE THE PROGRESS NOTES?"

BY TYPE OF PROVIDER

X1G	COUNT	TYPE PROFESSIONAL	ROW TOTAL
		1	
EVERY PNT	1	9	9
			45.0
MOST PNTS	2	5	5
			25.0
RARELY	3	2	2
			10.0
NEVER	4	4	4
			20.0
	COLUMN TOTAL	20	20
		100.0	100.0

NUMBER OF MISSING OBSERVATIONS = 113

Table 45

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

"DURING THE TEST PERIOD, HOW OFTEN DID YOU USE THE OTHER FORMS TO REVIEW NURSING CARE?"

BY TYPE OF PROVIDER

EMPTY DATA SET

Table 46

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

"PRIOR TO THE TEST PERIOD, HOW OFTEN HAD YOU USED THE NURSING HISTORY AND ASSESSMENT TO LEARN ABOUT NURSING ACTIVITIES AND THE PATIENT'S CONDITION?"

BY TYPE OF PROVIDER

X3A	COUNT	TYPE 4 PROFESSIONAL	ROW TOTAL
EVERY PNT	1	1	1
			5.0
MOST PNTS	2	3	3
			15.0
RARELY	3	11	11
			55.0
NEVER	4	5	5
			25.0
	COLUMN TOTAL	20	20
		100.0	100.0

NUMBER OF MISSING OBSERVATIONS = 113

Table 47

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

"PRIOR TO THE TEST PERIOD, HOW OFTEN HAD YOU USED THE NURSING CARE PLAN TO LEARN ABOUT NURSING ACTIVITIES AND THE PATIENT'S CONDITION?"

BY TYPE OF PROVIDER

X3B	COUNT / TYPE: PROFESSIONAL (4)	ROW TOTAL
3 RARELY	10	10 50.0
4 NEVER	10	10 50.0
COLUMN TOTAL	20 100.0	20 100.0

NUMBER OF MISSING OBSERVATIONS = 113

Table 48

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

"PRIOR TO THE TEST PERIOD, HOW OFTEN HAD YOU USED THE NURSING DISCHARGE SUMMARY TO LEARN ABOUT NURSING ACTIVITIES AND THE PATIENT'S CONDITION?"

BY TYPE OF PROVIDER

		TYPE	
	COUNT	PROFESSIONAL	ROW TOTAL
		4	
X3C			
2		1	1
MOST PNTS			5.0
3		7	7
RARELY			35.0
4		12	12
NEVER			60.0
	COLUMN TOTAL	20	20
		100.0	100.0

NUMBER OF MISSING OBSERVATIONS = 113

Table 49

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

"PRIOR TO THE TEST PERIOD, HOW OFTEN HAD YOU USED THE THERAPEUTIC DOCUMENTATION CARE PLAN, NONMEDICATION?"

BY TYPE OF PROVIDER

X3D	COUNT	TYPE: PROFESSIONAL	ROW TOTAL
		41	
EVERY PNT	1	1	1
			5.0
MOST PNTS	2	2	2
			10.0
RARELY	3	6	6
			30.0
NEVER	4	11	11
			55.0
	COLUMN TOTAL	20	20
		100.0	100.0

NUMBER OF MISSING OBSERVATIONS = 113

Table 50

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

"PRIOR TO THE TEST PERIOD, HOW OFTEN HAD YOU USED THE THERAPEUTIC DOCUMENTATION CARE PLAN, MEDICATION?"

BY TYPE OF PROVIDER

X3E	COUNT / TYPE: PROFESSIONAL (4)	ROW TOTAL
1 EVERY PNT	1	1
	5.0	5.0
2 MOST PNTS	5	5
	25.0	25.0
3 RARELY	8	8
	40.0	40.0
4 NEVER	6	6
	30.0	30.0
COLUMN TOTAL	20	20
	100.0	100.0

NUMBER OF MISSING OBSERVATIONS = 113

Table 51

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

"PRIOR TO THE TEST PERIOD, HOW OFTEN HAD YOU USED THE TPR GRAPHIC?"

BY TYPE OF PROVIDER

X3F	COUNT	TYPE: PROFESSIONAL (4)	ROW TOTAL
EVERY PNT	1	14	14
			70.0
MOST PNTS	2	3	3
			15.0
RARELY	3	1	1
			5.0
NEVER	4	2	2
			10.0
	COLUMN TOTAL	20	20
		100.0	100.0

NUMBER OF MISSING OBSERVATIONS = 113

Table 52

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

"PRIOR TO THE TEST PERIOD, HOW OFTEN HAD YOU USED THE NURSING NOTES?"

BY TYPE OF PROVIDER

X36	COUNT	TYPE: PROFESSIONAL (4)	ROW TOTAL
EVERY PNT	1	1	1
			5.0
MOST PNTS	2	8	8
			40.0
RARELY	3	8	8
			40.0
NEVER	4	3	3
			15.0
	COLUMN TOTAL	20	20
		100.0	100.0

NUMBER OF MISSING OBSERVATIONS = 113

Table 53

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

"PRIOR TO THE TEST PERIOD, HOW OFTEN DID YOU USE OTHER FORMS TO REVIEW NURSING CARE?"

BY TYPE OF PROVIDER

		TYPE	
	COUNT	PROFESSIONAL (4)	ROW TOTAL
X3H			
3 RARELY	1	1	1
			50.0
4 NEVER	1	1	1
			50.0
	COLUMN TOTAL	2	2
		100.0	100.0

NUMBER OF MISSING OBSERVATIONS = 131

Table 54

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

"DOCTOR'S ORDERS MEDICATION/DOCTOR'S ORDERS NONMEDICATION

(DA FORM 4256-1 TEST; DA FORM 4256-2 TEST) - HAVING

TWO SEPARATE ORDER SHEETS CAUSED MINIMAL

DIFFICULTIES FOR ME"

BY TYPE OF PROVIDER

D3	COUNT / TYPE	IRNS 1	PARA 2	WARD CLERK 3	PROFES-SIONAL 4	ROW TOTAL
1 STRONGLY AGREE		19	14	3	2	38
						30.2
2 AGREE		25	28	1	3	57
						45.2
3 DISAGREE		3	7	2	8	20
						15.9
4 STRONGLY DISAGRE		5	1		5	11
						8.7
	COLUMN TOTAL	52	53	6	18	126
		41.3	39.7	4.8	14.3	100.0

NUMBER OF MISSING OBSERVATIONS = 7

Table 55

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

"DOCTOR'S ORDERS MEDICATION/DOCTOR'S ORDERS NONMEDICATION

(DA FORM 4256-1 TEST; DA FORM 4256-2 TEST) - ORDERS

SHOULD CONTINUE TO REMAIN SEPARATED ON COLOR

CODED MEDICATION AND NONMEDICATION SHEETS"

BY TYPE OF PROVIDER

D4	COUNT / TYPE	IRNS 1	PARA 2	WARD CLERK 3	PROFES-SIONAL 4	ROW TOTAL
1 STRONGLY AGREE		28	25	4	1	58
						46.0
2 AGREE		15	21	2	5	43
						34.1
3 DISAGREE		3	3	1	4	11
						8.7
4 STRONGLY DISAGRE		5	1		8	14
						11.1
	COLUMN TOTAL	51	50	7	18	126
		40.5	39.7	5.5	14.3	100.0

NUMBER OF MISSING OBSERVATIONS = 7

Table 56

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

"DOCTOR'S ORDERS MEDICATION/DOCTOR'S ORDERS NONMEDICATION (DA FORM 4256-1 TEST; DA FORM 4256-2 TEST) - PRIOR TO THE TEST PERIOD, IF UNFAMILIAR WITH A PATIENT, I MOST OFTEN DETERMINED CURRENT MEDICATION(S) BY . . ."

BY TYPE OF PROVIDER

D6	COUNT	TYPE PROFESSIONAL	ROW TOTAL
		41	
REVIEW ALL DR OR	1	10	10
			58.8
REVIEW TD-MED	2	5	5
			29.4
ASK NURSE	3	1	1
			5.9
OTHER	4	1	1
			5.9
	COLUMN TOTAL	17	17
		100.0	100.0

NUMBER OF MISSING OBSERVATIONS = 116

Table 57

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

"DOCTOR'S ORDERS MEDICATION/DOCTOR'S ORDERS NONMEDICATION

(DA FORM 4256-1 TEST; DA FORM 4256-2 TEST) -

DURING THE TEST PERIOD, AFTER THE SEPARATION OF ORDERS,

IF UNFAMILIAR WITH A PATIENT, I MOST OFTEN DETERMINED

CURRENT MEDICATION(S) BY . . ."

BY TYPE OF PROVIDER

D7	COUNT	TYPE PROFESSIONAL	ROW TOTAL
REVIEW ALL DR OR	1	11	11 64.7
REVIEW TO-MED	2	4	4 23.5
ASK NURSE	3	1	1 5.9
OTHER	4	1	1 5.9
	COLUMN TOTAL	17 100.0	17 100.0

NUMBER OF MISSING OBSERVATIONS = 116

Table 58

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

"DOCTOR'S ORDERS MEDICATION/DOCTOR'S ORDERS NONMEDICATION

(DA FORM 4256-1 TEST; DA FORM 4256-2 TEST) -

IF WE WENT BACK TO THE 'OLD' ORDER SHEETS, I WOULD

HAVE NO DIFFICULTY IDENTIFYING COMPLETED SINGLE

ACTION ORDERS"

BY TYPE OF PROVIDER

D8	COUNT / TYPE	IRNS 1	PARA 2	WARD CLERK 3	ROW TOTAL
1		9	8		17
STRONGLY AGREE					16.3
2		17	15	3	36
AGREE					34.6
3		16	19	2	37
DISAGREE					35.6
4		7	6	1	14
STRONGLY DISAGRE					13.5
	COLUMN TOTAL	49	49	6	104
		47.1	47.1	5.8	100.0

NUMBER OF MISSING OBSERVATIONS = 29

Table 59

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

"DOCTOR'S ORDERS MEDICATION/DOCTOR'S ORDERS NONMEDICATION

(DA FORM 4256-1 TEST; DA FORM 4256-2 TEST) -

IF WE WENT BACK TO THE 'OLD' ORDER SHEETS, I WOULD STILL

WANT A COLUMN FOR SINGLE ACTION ORDERS TO PRECLUDE

MY HAVING TO RECOPY THEM ONTO THE THERAPEUTIC

DOCUMENTATION CARE PLANS"

BY TYPE OF PROVIDER

D9	COUNT / TYPE	IRNS (1)	PARA (2)	WARD CLERK (3)	ROW TOTAL
1	STRONGLY AGREE	28	15	1	44
					42.3
2	AGREE	13	24	5	42
					40.4
3	DISAGREE	7	9		16
					15.4
4	STRONGLY DISAGREE	1	1		2
					1.9
	COLUMN TOTAL	49	49	6	104
		47.1	47.1	5.8	100.0

NUMBER OF MISSING OBSERVATIONS = 29

Table 60

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

I LIKE BEING ABLE TO DOCUMENT (WITH EFFECTIVENESS CODES OR KEY WORDS) THE PATIENT'S RESPONSE DIRECTLY ON THE THERAPEUTIC DOCUMENTATION CARE PLANS"

BY TYPE OF PROVIDER

E1	COUNT	TYPE IRNS 1	PARA 2	ROW TOTAL
STRONELY AGREE	1	31	15	46
				48.4
AGREE	2	16	29	45
				47.4
DISAGREE	3	1	3	4
				4.2
	COLUMN TOTAL	48	47	95
		50.5	49.5	100.0

NUMBER OF MISSING OBSERVATIONS = 38

Table 61

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

"MOST OF MY DOCUMENTATION IS RECORDED ON THE THERAPEUTIC DOCUMENTATION CARE PLANS"

BY TYPE OF PROVIDER

E2	COUNT	TYPE PARA 2	ROW TOTAL
1 STRONGLY AGREE	1	11	11
		24.4	
AGREE	2	26	26
		57.8	
DISAGREE	3	7	7
		15.6	
STRONGLY DISAGRE	4	1	1
		2.2	
	COLUMN TOTAL	45	45
		100.0	100.0

NUMBER OF MISSING OBSERVATIONS = 88

Table 62

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

"IN THE PAST, I USED TO DO MOST OF MY DOCUMENTING ON

THE NURSING NOTES (SF 510)"

BY TYPE OF PROVIDER

		TYPE	
	COUNT	PARA	ROW TOTAL
		21	
E3			
1	15		15
STRONGLY AGREE			31.9
2	31		31
AGREE			66.0
4	1		1
STRONGLY DISAGRE			2.1
COLUMN TOTAL	47		47
	100.0		100.0

NUMBER OF MISSING OBSERVATIONS = 86

Table 63

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

"RECORDING THE PATIENT'S RESPONSE ON THE TD CARE PLAN

IMPROVES MY DOCUMENTATION OF PATIENT CARE"

BY TYPE OF PROVIDER

E4	COUNT	TYPE 1 RNS	PARA 11	RDN 21	TOTAL
1 STRONGLY AGREE		18	9		27
					28.4
2 AGREE		24	34		58
					61.1
3 DISAGREE		4	5		9
					9.5
4 STRONGLY DISAGRE		1			1
					1.1
	COLUMN TOTAL	47	48		95
		49.5	50.5		100.0

NUMBER OF MISSING OBSERVATIONS = 38

Table 64

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

"RECORDING THE PATIENT'S RESPONSE ON THE THERAPEUTIC DOCUMENTATION CARE PLAN ENCOURAGES ME TO WRITE MORE NURSING ORDERS TO DESCRIBE NURSING ACTIVITIES WITH THE PATIENT"

BY TYPE OF PROVIDER

E5	COUNT	TYPE RNS	ROW TOTAL
STRONGLY AGREE	1	13	13 28.3
AGREE	2	26	26 56.5
DISAGREE	3	6	6 13.0
STRONGLY DISAGRE	4	1	1 2.2
	COLUMN TOTAL	46 100.0	46 100.0

NUMBER OF MISSING OBSERVATIONS = 87

Table 65

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

"RECORDING THE PATIENT'S RESPONSE ON THE THERAPEUTIC DOCUMENTATION CARE PLAN IMPROVES COMMUNICATION AMONG NURSING PERSONNEL"

BY TYPE OF PROVIDER

E6	COUNT	TYPE 1 RNS	TYPE 2 PARA	ROW TOTAL
1 STRONGLY AGREE		11	9	20
				21.1
2 AGREE		26	31	57
				60.0
3 DISAGREE		10	8	18
				18.9
	COLUMN TOTAL	47	48	95
		49.5	50.5	100.0

NUMBER OF MISSING OBSERVATIONS = 38

Table 66

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

"RECORDING THE PATIENT'S RESPONSE ON THE THERAPEUTIC DOCUMENTATION CARE PLAN IMPROVES COMMUNICATION BETWEEN NURSES AND OTHER HEALTH CARE PROVIDERS"

BY TYPE OF PROVIDER

E7	COUNT	TYPE IRNS 11	PARA 21	ROW TOTAL
1 STRONGLY AGREE		10	8	18 19.1
2 AGREE		21	31	52 55.3
3 DISAGREE		15	7	22 23.4
4 STRONGLY DISAGRE		1	1	2 2.1
	COLUMN TOTAL	47 50.0	47 50.0	94 100.0

NUMBER OF MISSING OBSERVATIONS = 39

Table 67

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

"RECORDING THE PATIENT'S RESPONSE ON THE TD CARE PLAN HAS DECREASED FRAGMENTED DOCUMENTATION IN THE RECORD"

BY TYPE OF PROVIDER

E8	COUNT	TYPE IRNS (1)	TYPE PARA (2)	ROW TOTAL
STRONGLY AGREE	1	15	10	25
				26.9
AGREE	2	26	29	55
				59.1
DISAGREE	3	6	7	13
				14.0
	COLUMN TOTAL	47	46	93
		50.5	49.5	100.0

NUMBER OF MISSING OBSERVATIONS = 40

Table 68

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

"RECORDING THE PATIENT'S RESPONSE ON THE TD CARE PLAN ALLOWS ME TO GIVE A MORE THOROUGH REPORT"

BY TYPE OF PROVIDER

E9	COUNT	TYPE RNS 11	ROW TOTAL
STRONGLY AGREE	1	13	13 28.3
AGREE	2	24	24 52.2
DISAGREE	3	9	9 19.6
	COLUMN TOTAL	46 100.0	46 100.0

NUMBER OF MISSING OBSERVATIONS = 87

Table 69

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

"RECORDING THE PATIENT'S RESPONSE ON THE TD CARE PLAN GIVES ME A BETTER 'PICTURE' OF WHAT HAPPENED TO THE PATIENT"

BY TYPE OF PROVIDER

E10	COUNT / TYPE	IRNS (11)	PARA (21)	ROW TOTAL
STRONGLY AGREE	1	12	7	19
				20.4
AGREE	2	29	33	62
				66.7
DISAGREE	3	4	7	11
				11.8
STRONGLY DISAGREE	4	1		1
				1.1
	COLUMN TOTAL	46	47	93
		49.5	50.5	100.0

NUMBER OF MISSING OBSERVATIONS = 40

Table 70

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

"I DID NOT DOCUMENT PATIENT RESPONSES ON THE THERAPUETIC DOCUMENTATION CARE PLANS"

BY TYPE OF PROVIDER

E11	TYPE IRNS (1)	PARA (2)	ROW TOTAL
1 STRONGLY AGREE	1	3	4
	4.3		
2 AGREE	1	14	15
	16.3		
3 DISAGREE	26	26	52
	56.5		
4 STRONGLY DISAGRE	17	4	21
	22.8		
COLUMN TOTAL	45	47	92
	48.9	51.1	100.0

NUMBER OF MISSING OBSERVATIONS = 41

Table 71

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

"I HAD MINIMAL DIFFICULTY RECORDING THE PATIENT'S RESPONSES ON THE THERAPEUTIC DOCUMENTATION CARE PLAN"

BY TYPE OF PROVIDER

E12	TYPE COUNT I	RNS 1	PARA 2	ROW TOTAL
1 STRONGLY AGREE		10 15.6	4 14.8	14 15.6
2 AGREE		26 40.6	29 53.7	55 61.1
3 DISAGREE		7 10.9	10 18.5	17 18.9
4 STRONGLY DISAGRE		3 4.7	1 1.9	4 4.4
COLUMN TOTAL		46 51.1	44 48.9	90 100.0

NUMBER OF MISSING OBSERVATIONS = 43

Table 72

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

"THE EXPANDED USE OF THE THERAPEUTIC DOCUMENTATION CARE PLAN (BEING ABLE TO DOCUMENT RESPONSES) IS A CONCEPT WHICH SHOULD BE AVAILABLE TO ALL NURSING PERSONNEL WORLDWIDE"

BY TYPE OF PROVIDER

E13	COUNT	TYPE IRNS 11	PARA 21	ROW TOTAL
STRONGLY AGREE	1	25	11	36
				40.4
AGREE	2	20	29	49
				55.1
DISAGREE	3		3	3
				3.4
STRONGLY DISAGRE	4	1		1
				1.1
	COLUMN TOTAL	46 51.7	43 48.3	89 100.0

NUMBER OF MISSING OBSERVATIONS = 44

Table 73

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

"THE 'FOLDER' TYPE FORMAT OF THE THERAPEUTIC DOCUMENTATION CARE PLANS IS AN IMPROVEMENT"

BY TYPE OF PROVIDER

E14	TYPE COUNT RNS 1	PARA 2	WARD CLERK 3	ROW TOTAL
1 STRONGLY AGREE	16	13	2	31 29.0
2 AGREE	20	30	3	53 49.5
3 DISAGREE	11	5	2	18 16.8
4 STRONGLY DISAGRE	3	2		5 4.7
COLUMN TOTAL	50 46.7	50 46.7	7 6.5	107 100.0

NUMBER OF MISSING OBSERVATIONS = 26

Table 74

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

"THE 'FOLDER' TYPE FORMAT OF THE THERAPEUTIC DOCUMENTATION CARE PLANS SHOULD BE KEPT EVEN IF IT CANNOT BE OVERPRINTED WITH ORDERS"

BY TYPE OF PROVIDER

E15	COUNT	TYPE RNS 1	PARA 2	WARD CLERK 3	ROW TOTAL
1 STRONGLY AGREE		13	10	1	24
					23.3
2 AGREE		11	30	1	42
					40.8
3 DISAGREE		15	7	4	26
					25.2
4 STRONGLY DISAGRE		8	3		11
					10.7
	COLUMN TOTAL	47 45.6	50 48.5	6 5.8	103 100.0

NUMBER OF MISSING OBSERVATIONS = 30

Table 75

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

"THE 'FOLDER' TYPE FORMAT OF THE THERAPEUTIC DOCUMENTATION CARE PLANS SHOULD HAVE THE PATIENT IDENTIFICATION BLOCK PRINTED ON ALL PAGES"

BY TYPE OF PROVIDER

E16	COUNT	TYPE 1 IRNS	PARA	2 WARD CLERK	3	ROW TOTAL
1 STRONGLY AGREE	1	15	11			26
						25.2
2 AGREE	2	14	21	4		39
						37.9
3 DISAGREE	3	14	14	3		31
						30.1
4 STRONGLY DISAGRE	4	5	2			7
						6.8
	COLUMN TOTAL	48 46.6	48 46.6	7 6.8		103 100.0

NUMBER OF MISSING OBSERVATIONS = 30

Table 76

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

"I LIKE THE STURDIER PAPER ON WHICH THE FORMS ARE PRINTED"

BY TYPE OF PROVIDER

E17	COUNT / TYPE	IRNS (1)	PARA (2)	WARD CLERK (3)	ROW TOTAL
1	STRONGLY AGREE	18	19	2	39
					36.1
2	AGREE	19	23	3	45
					41.7
3	DISAGREE	9	9	2	20
					18.5
4	STRONGLY DISAGREE	4			4
					3.7
	COLUMN TOTAL	50	51	7	108
		46.3	47.2	6.5	100.0

NUMBER OF MISSING OBSERVATIONS = 25

Table 77

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

"HAVING SEPARATE PAGES FOR RECURRING, DELAYED, OR PRN ACTION ORDERS IS HELPFUL TO ME"

BY TYPE OF PROVIDER

E18	COUNT	TYPE IRNS 1	PARA 2	WARD CLERK 3	ROW TOTAL
1 STRONGLY AGREE		23	14	1	38
		38.0			
2 AGREE		20	30	4	54
		54.0			
3 DISAGREE		2	3	1	6
		6.0			
4 STRONGLY DISAGRE		2	1	1	2
		2.0			
	COLUMN TOTAL	47	47	6	100
		47.0	47.0	6.0	100.0

NUMBER OF MISSING OBSERVATIONS = 33

Table 78

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

"TO MY KNOWLEDGE, THERE WERE NO TREATMENT OR MEDICATION ERRORS COMMITTED ON MY NURSING UNIT WHICH COULD BE BLAMED ON THE NEW FORMAT OF THE THERAPEUTIC DOCUMENTATION CARE PLANS"

BY TYPE OF PROVIDER

E19	COUNT	TYPE 1 RNS	2 PARA	ROW TOTAL
1 STRONGLY AGREE	1	18	8	26
				28.0
2 AGREE	2	22	32	54
				58.1
3 DISAGREE	3	6	4	10
				10.8
4 STRONGLY DISAGREE	4	1	2	3
				3.2
	COLUMN TOTAL	47	46	93
		50.5	49.5	100.0

NUMBER OF MISSING OBSERVATIONS = 40

Table 79

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

"I WOULD PREFER TO HAVE THE THERAPEUTIC DOCUMENTATION CARE PLANS IN A SINGLE SHEET FORMAT (LIKE THE 'OLD' TDs) EVEN KNOWING THAT I WOULD HAVE LESS ROOM FOR DOCUMENTATION"

BY TYPE OF PROVIDER

E2D	COUNT	TYPE: 1 IRNS	2 PARA	3 WARD CLERK	ROW TOTAL
1		3	5		8
STRONGLY AGREE					8.1
2		7	9	3	19
AGREE					19.2
3		22	24	3	49
DISAGREE					49.5
4		16	7		23
STRONGLY DISAGREE					23.2
COLUMN TOTAL		48	45	6	99
		48.5	45.5	6.1	100.0

NUMBER OF MISSING OBSERVATIONS = 34

Table 80

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

"IF A SINGLE SHEET FORMAT WERE TO BE USED, I WOULD PREFER A MEDIUM WEIGHT PAPER (LESS BULKY THAN THE TESTED PAPER)"

BY TYPE OF PROVIDER

E21	COUNT / TYPE	IRNS (1)	PARA (2)	WARD CLERK (3)	ROW TOTAL
1	STRONGLY AGREE	8	5	1	14
					13.7
2	AGREE	14	13	2	34
					33.3
3	DISAGREE	18	18	3	39
					38.2
4	STRONGLY DISAGREE	8	5	1	15
					14.7
	COLUMN TOTAL	48	47	7	102
		47.1	46.1	6.9	100.0

NUMBER OF MISSING OBSERVATIONS = 31

Table 81

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

"ALL MEDICATION AND NONMEDICATION FORMS SHOULD REMAIN COLOR CODED"

BY TYPE OF PROVIDER

E22	COUNT	TYPE IRNS 1	PARA 2	WARD CLERK 3	ROW TOTAL
1 STRONGLY AGREE		32	21	5	58
					55.8
2 AGREE		14	27	2	43
					41.3
3 DISAGREE			1		1
					1.0
4 STRONGLY DISAGRE		2			2
					1.9
	COLUMN TOTAL	48	49	7	104
		46.2	47.1	6.7	100.0

NUMBER OF MISSING OBSERVATIONS = 29

Table 82

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

"YELLOW HIGHLIGHTER USE SHOULD BE REINSTATED TO DISCONTINUE ORDERS"

BY TYPE OF PROVIDER

E23	COUNT	TYPE IRNS 1	PARA 2	WARD CLERK 3	ROW TOTAL
1 STRONGLY AGREE		25	17	1	43 41.0
2 AGREE		9	19	3	31 29.5
3 DISAGREE		12	10	1	23 21.9
4 STRONGLY DISAGRE		3	3	2	8 7.6
	COLUMN TOTAL	49 46.7	49 46.7	7 6.7	105 100.0

NUMBER OF MISSING OBSERVATIONS = 28

Table 83

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

"THE INTEGRATED PROGRESS NOTE IMPROVES COMMUNICATIONS CONCERNING THE PATIENT AMONG ALL HEALTH CARE PROVIDERS"

BY TYPE OF PROVIDER

F1	COUNT / TYPE	IRNS 1	PARA 2	PROFESSIONAL 4	ROW TOTAL
1	STRONGLY AGREE	27	15	4	46
					38.7
2	AGREE	20	30	7	57
					47.9
3	DISAGREE	2	3	5	10
					8.4
4	STRONGLY DISAGREE	2	1	3	6
					5.0
	COLUMN TOTAL	51	49	19	119
		42.9	41.2	16.0	100.0

NUMBER OF MISSING OBSERVATIONS = 14

Table 84

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

"THE INTEGRATED PROGRESS NOTE HAS ENCOURAGED ME TO BE MORE THOROUGH IN DOCUMENTATION"

BY TYPE OF PROVIDER

F2	COUNT	TYPE IRNS (1)	PARA (2)	ROW TOTAL
1 STRONGLY AGREE		14	10	24
		24.5		
2 AGREE		22	28	50
		51.0		
3 DISAGREE		11	10	21
		21.4		
4 STRONGLY DISAGRE		3		3
		3.1		
COLUMN TOTAL		50	48	98
		51.0	49.0	100.0

NUMBER OF MISSING OBSERVATIONS = 35

Table 85

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

"THE INTEGRATED PROGRESS NOTE HAS ENCOURAGED ME TO BE MORE CONCISE IN DOCUMENTATION"

BY TYPE OF PROVIDER

F3	COUNT / TYPE	IRNS (1)	PARA (2)	ROW TOTAL
1	STRONGLY AGREE	13	12	25
		25.5	26.1	25.8
2	AGREE	33	28	61
		64.7	60.9	62.9
3	DISAGREE	4	6	10
		7.8	13.0	10.3
4	STRONGLY DISAGREE	1		1
		2.0		1.0
	COLUMN TOTAL	51	46	97
		52.6	47.4	100.0

NUMBER OF MISSING OBSERVATIONS = 36

Table 86

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

"THE INTEGRATED PROGRESS NOTE LESSENS FRAGMENTING OF INFORMATION IN THE PATIENT RECORD"

BY TYPE OF PROVIDER

F4	COUNT	TYPE IRNS (1)	PARA (2)	PROFES-SIONAL (4)	ROW TOTAL
1 STRONGLY AGREE		17	13	4	34
					29.3
2 AGREE		30	28	7	65
					56.0
3 DISAGREE		4	5	5	14
					12.1
4 STRONGLY DISAGRE				3	3
					2.6
COLUMN TOTAL		51	46	19	116
		44.0	39.7	16.4	100.0

NUMBER OF MISSING OBSERVATIONS = 17

Table 87

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

"THE INTEGRATED PROGRESS NOTE LESSENS THE AMOUNT OF INFORMATION EVERYONE MUST DOCUMENT"

BY TYPE OF PROVIDER

F5	TYPE 1 IRNS	11 PARA	21 PROFES-SIONAL	41	ROW TOTAL
1 STRONGLY AGREE	13	11	3		27 22.9
2 AGREE	30	30	5		65 55.1
3 DISAGREE	8	7	7		22 18.6
4 STRONGLY DISAGREE			4		4 3.4
COLUMN TOTAL	51 43.2	48 40.7	19 16.1		118 100.0

NUMBER OF MISSING OBSERVATIONS = 15

Table 88

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

"THE INTEGRATED PROGRESS NOTE ENCOURAGES ME TO READ NARRATIVE NURSING NOTES MORE THAN I DID IN THE PAST"

BY TYPE OF PROVIDER

F6	COUNT	TYPE PROFESSIONAL 4	ROW TOTAL
1 STRONGLY AGREE	1	4	4 21.1
AGREE	2	9	9 47.4
DISAGREE	3	2	2 10.5
STRONGLY DISAGREE	4	4	4 21.1
	COLUMN TOTAL	19 100.0	19 100.0

NUMBER OF MISSING OBSERVATIONS = 114

Table 89

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

"THE INTEGRATED PROGRESS NOTE MAKES IT EASIER TO

DETERMINE WHAT IS HAPPENING WITH MY PATIENT"

BY TYPE OF PROVIDER

F7	COUNT / TYPE	PROFESSIONAL 4	ROW TOTAL
1 STRONGLY AGREE		3	3
		15.8	15.8
2 AGREE		6	6
		31.6	31.6
3 DISAGREE		5	5
		26.3	26.3
4 STRONGLY DISAGREE		5	5
		26.3	26.3
COLUMN TOTAL		19	19
		100.0	100.0

NUMBER OF MISSING OBSERVATIONS = 114

Table 90

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

"THE INTEGRATED PROGRESS NOTE HAS SAVED ME TIME IN DOCUMENTING

(I FEEL I DON'T NEED TO REPEAT INFORMATION PREVIOUSLY

DOCUMENTED BY ANOTHER HEALTH CARE PROVIDER BECAUSE

IT'S ALL IN THE SAME PLACE)"

BY TYPE OF PROVIDER

FB	TYPE 1 IRNS	TYPE 2 PARA	ROW TOTAL
1 STRONGLY AGREE	21	13	34
			35.4
2 AGREE	18	29	47
			49.0
3 DISAGREE	7	6	13
			13.5
4 STRONGLY DISAGRE	2		2
			2.1
COLUMN TOTAL	48	48	96
	50.0	50.0	100.0

NUMBER OF MISSING OBSERVATIONS = 37

Table 91

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

"THE INTEGRATED PROGRESS NOTE ENCOURAGES ME TO READ OTHER CARE PROVIDERS' NOTES"

BY TYPE OF PROVIDER

F9	COUNT / TYPE	IRNS (1)	PARA (2)	ROW TOTAL
1 STRONGLY AGREE		24	16	40
				40.4
2 AGREE		26	27	53
				53.5
3 DISAGREE		1	5	6
				6.1
	COLUMN TOTAL	51	48	99
		51.5	48.5	100.0

NUMBER OF MISSING OBSERVATIONS = 34

Table 92

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

"THE INTEGRATED PROGRESS NOTE SHOULD BE USED AT ALL ARMY HOSPITALS"

BY TYPE OF PROVIDER

F10	COUNT	TYPE IRNS 1	PARA 2	PROFESSIONAL 4	ROW TOTAL
1 STRONGLY AGREE		28	19	5	52
					44.1
2 AGREE		21	27	5	53
					44.9
3 DISAGREE		1	2	4	7
					5.9
4 STRONGLY DISAGREE		1		5	6
					5.1
	COLUMN TOTAL	51	48	19	118
		43.2	40.7	16.1	100.0

NUMBER OF MISSING OBSERVATIONS = 15

Table 93

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

"I HAD LITTLE DIFFICULTY IDENTIFYING WHO WROTE PREVIOUS NARRATIVE NOTATIONS"

BY TYPE OF PROVIDER

F11	COUNT	TYPE PROFESSIONAL (4)	ROW TOTAL
1 STRONGLY AGREE	1	2	2
			10.5
2 AGREE	2	11	11
			57.9
3 DISAGREE	3	4	4
			21.1
4 STRONGLY DISAGRE	4	2	2
			10.5
	COLUMN TOTAL	19	19
		100.0	100.0

NUMBER OF MISSING OBSERVATIONS = 114

Table 94

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

"I HAD NO DIFFICULTY DISTINGUISHING NURSING NOTATIONS FROM THOSE OF OTHER DISCIPLINES"

BY TYPE OF PROVIDER

F12	TYPE IRNS (1)	PARA (2)	PROFESSIONAL (4)	ROW TOTAL
1 STRONGLY AGREE	26	12	2	40 34.2
2 AGREE	21	26	14	61 52.1
3 DISAGREE	3	10	2	15 12.8
4 STRONGLY DISAGRE			1	1 .9
COLUMN TOTAL	50 42.7	48 41.0	19 16.2	117 100.0

NUMBER OF MISSING OBSERVATIONS = 16

Table 95

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

"I HAD LITTLE DIFFICULTY LOCATING MY PREVIOUS NARRATIVE NOTATIONS"

BY TYPE OF PROVIDER

F13	COUNT	TYPE PROFESSIONAL 4	ROW TOTAL
1 STRONGLY AGREE	1	1	5.3
2 AGREE	5	5	26.3
3 DISAGREE	9	9	47.4
4 STRONGLY DISAGRE	4	4	21.1
COLUMN TOTAL	19	19	100.0

NUMBER OF MISSING OBSERVATIONS: 114

Table 96

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

"PHYSICIANS ON MY NURSING UNIT SEEMED TO LIKE HAVING NARRATIVE NURSING COMMENTS INTEGRATED WITH OTHER PATIENT CARE DOCUMENTATION"

BY TYPE OF PROVIDER

F14	COUNT	TYPE IRNS 1	TYPE PARA 2	ROW TOTAL
1		5	6	11
STRONGLY AGREE				12.0
2		27	29	56
AGREE				60.9
3		12	10	22
DISAGREE				23.9
4		2	1	3
STRONGLY DISAGRE				3.3
COLUMN TOTAL		46	46	92
		50.0	50.0	100.0

NUMBER OF MISSING OBSERVATIONS: 41

Table 97

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

"OTHER HEALTH CARE PROVIDERS (e.g., PHYSICAL THERAPIST, DIETITIAN, SOCIAL WORKER) SEEMED TO LIKE HAVING NARRATIVE NURSING COMMENTS INTEGRATED WITH OTHER PATIENT CARE DOCUMENTATION"

BY TYPE OF PROVIDER

F15	COUNT	TYPE IRNS 1	TYPE PARA 2	ROW TOTAL
STRONGLY AGREE	1	8	7	15
				16.9
AGREE	2	31	34	65
				73.0
DISAGREE	3	4	4	8
				9.0
STRONGLY DISAGRE	4	1		1
				1.1
	COLUMN TOTAL	44	45	89
		49.4	50.6	100.0

NUMBER OF MISSING OBSERVATIONS: 44

Table 98

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

"ALTHOUGH THE GUIDELINES READ THAT ALL NURSING PERSONNEL WERE AUTHORIZED TO CHART ON THE PROGRESS NOTES, THERE WERE SOME EXCEPTIONS TO THIS POLICY ON MY NURSING UNIT"

BY TYPE OF PROVIDER

F16	COUNT	TYPE IRNS 1	TYPE PARA 2	ROW TOTAL
1 STRONGLY AGREE		2	5	7
				7.3
2 AGREE		8	17	25
				26.0
3 DISAGREE		17	23	40
				41.7
4 STRONGLY DISAGRE		19	5	24
				25.0
	COLUMN TOTAL	46	50	96
		47.9	52.1	100.0

NUMBER OF MISSING OBSERVATIONS: 37

Table 99

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

"IN MY OPINION, THE BOTTOM LINE TO EVERYTHING WE HAVE TESTED IS. . ."

BY TYPE OF PROVIDER

G1	TYPE			
COUNT / ROW PCT / COL PCT	IRNS	PARA	WARD CLERK	ROW TOTAL
1 IMPLEMENT EXACTL	111	138	14	263
	42.2	52.5	5.3	53.1
	42.5	67.0	50.0	
2 GO BACK TO OLD	3	6	3	12
	25.0	50.0	25.0	2.4
	1.1	2.9	10.7	
3 IMPLEMENT W MODI	147	62	11	220
	66.8	28.2	5.0	44.4
	56.3	30.1	39.3	
COLUMN TOTAL	261	206	28	495
	52.7	41.6	5.7	100.0

NUMBER OF MISSING OBSERVATIONS: 351

Table 100

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

GENERAL COMMENTS REGARDING THE TEST FORMS

BY TYPE OF PROVIDER

COMMENTS	COUNT / ROW PCT / COL PCT / TAB PCT	TYPE IRN	PARA	WARD CLERK	PROFES-SIONAL	ROW TOTAL
1		3	17	9	7	36
DR ORDER +GEN SAT		8.3	47.2	25.0	19.4	19.3
		9.4	22.4	22.5	17.9	
		1.6	9.1	4.8	3.7	
2		1	6	0	3	10
DR ORD +SINGLE ACT		10.0	60.0	.0	30.0	5.3
		3.1	7.9	.0	7.7	
		.5	3.2	.0	1.6	
4		0	1	0	0	1
DR ORD-GEN-PAPERWRK		.0	100.0	.0	.0	.5
		.0	1.3	.0	.0	
		.0	.5	.0	.0	
5		2	1	1	0	4
DR ORD-CONFUS-TIME		50.0	25.0	25.0	.0	2.1
		6.3	1.3	2.5	.0	
		1.1	.5	.5	.0	
6		2	4	1	0	7
DR ORD-MISS ORDERS		28.6	57.1	14.3	.0	3.7
		6.3	5.3	2.5	.0	
		1.1	2.1	.5	.0	
7		0	0	0	1	1
DR ORD-STIL TRANSC		.0	.0	.0	100.0	.5
		.0	.0	.0	2.6	
		.0	.0	.0	.5	
8		5	4	3	3	15
DR ORD-MISC PROBLEM		33.3	26.7	20.0	20.0	8.0
		15.6	5.3	7.5	7.7	
		2.7	2.1	1.6	1.6	
	COLUMN TOTAL	32	76	40	39	187
		17.1	40.6	21.4	20.9	100.0

Table 100

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

GENERAL COMMENTS REGARDING THE TEST FORMS

BY TYPE OF PROVIDER (CONTINUED)

COMMENTS	TYPE: IRN (1)	PARA (2)	WARD CLERK (3)	PROFESSIONAL (4)	ROW TOTAL
9	6	17	13	4	40
OR ORD 1-SHEET PREFR	15.0	42.5	32.5	10.0	21.4
	18.8	22.4	32.5	10.3	
	3.2	9.1	7.0	2.1	
10	1	0	2	0	3
OR ORD REDISN COMMNT	33.3	.0	66.7	.0	1.6
	3.1	.0	5.0	.0	
	.5	.0	1.1	.0	
11	7	21	10	11	49
509+ GEN SATISFACT	14.3	42.9	20.4	22.4	26.2
	21.9	27.6	25.0	28.2	
	3.7	11.2	5.3	5.9	
12	0	1	2	2	5
509+IMPROVES COMMUN	.0	20.0	40.0	40.0	2.7
	.0	1.3	5.0	5.1	
	.0	.5	1.1	1.1	
13	0	2	5	0	7
509+ KEEP	.0	28.6	71.4	.0	3.7
	.0	2.6	12.5	.0	
	.0	1.1	2.7	.0	
14	1	1	0	1	3
509- GEN PROBLEMS	33.3	33.3	.0	33.3	1.6
	3.1	1.3	.0	2.6	
	.5	.5	.0	.5	
15	2	3	0	0	5
509-PARAPROF ENTRY	40.0	60.0	.0	.0	2.7
	6.3	3.9	.0	.0	
	1.1	1.6	.0	.0	
COLUMN TOTAL	32	76	40	39	187
	17.1	40.6	21.4	20.9	100.0

Table 100

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

GENERAL COMMENTS REGARDING THE TEST FORMS

BY TYPE OF PROVIDER (CONTINUED)

COMMENTS	COUNT / ROW PCT / COL PCT / TAB PCT	TYPE 1 IRN	2 PARA	3 WARD CLERK	4 PROFES-SIONAL	ROW TOTAL
16		1	2	2	0	5
509-DECR DOCU,LEGAL		20.0	40.0	40.0	.0	2.7
		3.1	2.6	5.0	.0	
		.5	1.1	1.1	.0	
17		1	2	0	1	4
509-MDS DONT LIKE		25.0	50.0	.0	25.0	2.1
		3.1	2.6	.0	2.6	
		.5	1.1	.0	.5	
19		0	0	0	1	1
509-CONFUS,FRAGMNT		.0	.0	.0	100.0	.5
		.0	.0	.0	2.6	
		.0	.0	.0	.5	
20		1	3	1	0	5
509-NOTES QUALITY		20.0	60.0	20.0	.0	2.7
		3.1	3.9	2.5	.0	
		.5	1.6	.5	.0	
21		0	2	0	0	2
509-ID OF SOURCE		.0	100.0	.0	.0	1.1
		.0	2.6	.0	.0	
		.0	1.1	.0	.0	
22		0	1	3	1	5
509 GO BACK TO SEP N		.0	20.0	60.0	20.0	2.7
		.0	1.3	7.5	2.6	
		.0	.5	1.6	.5	
24		3	17	10	4	34
3888-2 +GEN COMMENT		8.8	50.0	29.4	11.8	18.2
		9.4	22.4	25.0	10.3	
		1.6	9.1	5.3	2.1	
COLUMN TOTAL		32	76	40	39	187
		17.1	40.6	21.4	20.9	100.0

Table 100

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

GENERAL COMMENTS REGARDING THE TEST FORMS

BY TYPE OF PROVIDER (CONTINUED)

COMMENTS	TYPE 1 IRN	2 PARA	3 WARD CLERK	4 PROFES-SIONAL	ROW TOTAL
25	0	1	1	1	3
3888-2-OLD BETTER	.0	33.3	33.3	33.3	1.6
	.0	1.3	2.5	2.6	
	.0	.5	.5	.5	
26	7	15	6	12	40
3888-2 REDESIGN CMTS	17.5	37.5	15.0	30.0	21.4
	21.9	19.7	15.0	30.8	
	3.7	8.0	3.2	6.4	
27	0	1	0	0	1
3888-2 OVERPRINT CMT	.0	100.0	.0	.0	.5
	.0	1.3	.0	.0	
	.0	.5	.0	.0	
28	2	2	0	0	4
3888-2 SPECIFIC PROB	50.0	50.0	.0	.0	2.1
	6.3	2.6	.0	.0	
	1.1	1.1	.0	.0	
29	5	15	11	7	38
3888-3 + COMMENTS	13.2	39.5	28.9	18.4	20.3
	15.6	19.7	27.5	17.9	
	2.7	8.0	5.9	3.7	
30	2	11	2	2	17
3888-3-NEVER USE	11.8	64.7	11.8	11.8	9.1
	6.3	14.5	5.0	5.1	
	1.1	5.9	1.1	1.1	
31	3	18	11	7	39
3888-4+ COMMENTS	7.7	46.2	28.2	17.9	20.9
	9.4	23.7	27.5	17.9	
	1.6	9.6	5.9	3.7	
COLUMN TOTAL	32	76	40	39	187
	17.1	40.6	21.4	20.9	100.0

Table 100

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

GENERAL COMMENTS REGARDING THE TEST FORMS

BY TYPE OF PROVIDER (CONTINUED)

COMMENTS	TYPE: IRN (1)	PARA (2)	WARD CLERK (3)	PROFESSIONAL (4)	ROW TOTAL
32	0	0	1	1	2
3888-4-OLD BETTER	.0	.0	50.0	50.0	1.1
	.0	.0	2.5	2.6	
	.0	.0	.5	.5	
33	3	4	0	3	10
3388-4 REDESIGN CMTS	30.0	40.0	.0	30.0	5.3
	9.4	5.3	.0	7.7	
	1.6	2.1	.0	1.6	
34	1	0	0	0	1
3888-4 MISC COMMENTS	100.0	.0	.0	.0	.5
	3.1	.0	.0	.0	
	.5	.0	.0	.0	
35	2	20	11	12	45
3888-5+ KEEP	4.4	44.4	24.4	26.7	24.1
	6.3	26.3	27.5	30.8	
	1.1	10.7	5.9	6.4	
36	5	4	4	8	21
3888-5+REDESIGN CMT	23.8	19.0	19.0	38.1	11.2
	15.6	5.3	10.0	20.5	
	2.7	2.1	2.1	4.3	
37	0	6	0	1	7
3888-5+MULTIDISCIP	.0	85.7	.0	14.3	3.7
	.0	7.9	.0	2.6	
	.0	3.2	.0	.5	
38	1	6	2	0	9
3888-5-DEDUNDANT	11.1	66.7	22.2	.0	4.8
	3.1	7.9	5.0	.0	
	.5	3.2	1.1	.0	
COLUMN TOTAL	32	76	40	39	187
	17.1	40.6	21.4	20.9	100.0

Table 100

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

GENERAL COMMENTS REGARDING THE TEST FORMS

BY TYPE OF PROVIDER (CONTINUED)

COMMENTS	COUNT / ROW PCT / COL PCT / TAB PCT	TYPE IRN (1)	PARA (2)	WARD CLERK (3)	PROFES-SIONAL (4)	ROW TOTAL
3888-5 MIS COMMENTS	39	0	1	0	1	2
		.0	50.0	.0	50.0	1.1
		.0	1.3	.0	2.6	
		.0	.5	.0	.5	
TDS+KEEP,NO CHANGES	40	3	14	8	2	27
		11.1	51.9	29.6	7.4	14.4
		9.4	18.4	20.0	5.1	
		1.6	7.5	4.3	1.1	
TDS REDESIGN COMMNTS	41	8	15	6	13	42
		19.0	35.7	14.3	31.0	22.5
		25.0	19.7	15.0	33.3	
		4.3	8.0	3.2	7.0	
TDS CODING ISSUES	42	1	2	4	1	8
		12.5	25.0	50.0	12.5	4.3
		3.1	2.6	10.0	2.6	
		.5	1.1	2.1	.5	
TDS-OLD BETTER	43	3	7	3	1	14
		21.4	50.0	21.4	7.1	7.5
		9.4	9.2	7.5	2.6	
		1.6	3.7	1.6	.5	
TDS OVERPRINT COMMEN	44	8	2	1	3	14
		57.1	14.3	7.1	21.4	7.5
		25.0	2.6	2.5	7.7	
		4.3	1.1	.5	1.6	
GEN+SYS CHG CMTS	45	5	14	3	8	30
		16.7	46.7	10.0	26.7	16.0
		15.6	18.4	7.5	20.5	
		2.7	7.5	1.6	4.3	
	COLUMN TOTAL	32	76	40	39	187
		17.1	40.6	21.4	20.9	100.0

Table 100

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

GENERAL COMMENTS REGARDING THE TEST FORMS

BY TYPE OF PROVIDER (CONTINUED)

COMMENTS	COUNT / ROW PCT / COL PCT / TAB PCT	TYPE IRN (1)	PARA (2)	WARD CLERK (3)	PROFES-SIONAL (4)	ROW TOTAL
46		1	3	2	0	6
GEN -CMTS,OLD BETTR		16.7	50.0	33.3	.0	3.2
		3.1	3.9	5.0	.0	
		.5	1.6	1.1	.0	
47		1	5	1	0	7
OVERPRINT COMMENTS		14.3	71.4	14.3	.0	3.7
		3.1	6.6	2.5	.0	
		.5	2.7	.5	.0	
48		1	1	0	0	2
REDESIGN COMMENTS		50.0	50.0	.0	.0	1.1
		3.1	1.3	.0	.0	
		.5	.5	.0	.0	
49		1	7	0	2	10
SPECIFIC AREA PROBS		10.0	70.0	.0	20.0	5.3
		3.1	9.2	.0	5.1	
		.5	3.7	.0	1.1	
50		3	13	4	14	34
TDS WANT YELLOW HL		8.8	38.2	11.8	41.2	18.2
		9.4	17.1	10.0	35.9	
		1.6	7.0	2.1	7.5	
	COLUMN TOTAL	32	76	40	39	187
		17.1	40.6	21.4	20.9	100.0

PERCENTS AND TOTALS BASED ON RESPONDENTS

187 VALID CASES; 128 MISSING CASES

Table 101

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

GENERAL COMMENTS REGARDING DA FORM 3888-2 TEST NURSING HISTORY AND ASSESSMENT

BY TYPE OF PROVIDER

COMMENTS	TYPE: IRN (1)	PARA (2)	WARD CLERK (3)	PROFESSIONAL (4)	ROW TOTAL
3888-2 +GEN COMMENT	3	17	10	4	34
	8.8	50.0	29.4	11.8	41.5
	25.0	47.2	58.8	23.5	
	3.7	20.7	12.2	4.9	
3888-2-OLD BETTER	0	1	1	1	3
	.0	33.3	33.3	33.3	3.7
	.0	2.8	5.9	5.9	
	.0	1.2	1.2	1.2	
3888-2 REDESIGN CMTS	7	15	6	12	40
	17.5	37.5	15.0	30.0	48.8
	58.3	41.7	35.3	70.6	
	8.5	18.3	7.3	14.6	
3888-2 OVERPRINT CMT	0	1	0	0	1
	.0	100.0	.0	.0	1.2
	.0	2.8	.0	.0	
	.0	1.2	.0	.0	
3888-2 SPECIFIC PROB	2	2	0	0	4
	50.0	50.0	.0	.0	4.9
	16.7	5.6	.0	.0	
	2.4	2.4	.0	.0	
COLUMN TOTAL	12	36	17	17	82
	14.6	43.9	20.7	20.7	100.0

PERCENTS AND TOTALS BASED ON RESPONDENTS

82 VALID CASES; 233 MISSING CASES

Table 102

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

GENERAL COMMENTS REGARDING DA FORM 3888-3 TEST

NURSING HISTORY AND ASSESSMENT CONTINUATION

BY TYPE OF PROVIDER

COMMENTS	COUNT / ROW PCT / COL PCT / TAB PCT	TYPE 1 IRN	2 PARA	3 WARD CLERK	4 PROFES-SIONAL	ROW TOTAL
3888-3 + COMMENTS	29	5	15	11	7	38
		13.2	39.5	28.9	18.4	70.4
		71.4	60.0	84.6	77.8	
		9.3	27.8	20.4	13.0	
3888-3-NEVER USE	30	2	11	2	2	17
		11.8	64.7	11.8	11.8	31.5
		28.6	44.0	15.4	22.2	
		3.7	20.4	3.7	3.7	
COLUMN TOTAL		7	25	13	9	54
		13.0	46.3	24.1	16.7	100.0

PERCENTS AND TOTALS BASED ON RESPONDENTS

54 VALID CASES; 261 MISSING CASES

Table 103

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

GENERAL COMMENTS REGARDING DA FORM 3888-4 TEST

NURSING CARE PLAN

BY TYPE OF PROVIDER

COMMENTS	COUNT / ROW PCT / COL PCT / TAB PCT	TYPE IRN (1)	PARA (2)	WARD CLERK (3)	PROFESSIONAL (4)	ROW TOTAL
31		3	18	11	7	39
3888-4+ COMMENTS		7.7	46.2	28.2	17.9	75.0
		42.9	81.8	91.7	63.6	
		5.8	34.6	21.2	13.5	
32		0	0	1	1	2
3888-4-OLD BETTER		.0	.0	50.0	50.0	3.8
		.0	.0	8.3	9.1	
		.0	.0	1.9	1.9	
33		3	4	0	3	10
3888-4 REDESIGN CMTS		30.0	40.0	.0	30.0	19.2
		42.9	18.2	.0	27.3	
		5.8	7.7	.0	5.8	
34		1	0	0	0	1
3888-4 MISC COMMENTS		100.0	.0	.0	.0	1.9
		14.3	.0	.0	.0	
		1.9	.0	.0	.0	
COLUMN TOTAL		7	22	12	11	52
		13.5	42.3	23.1	21.2	100.0

PERCENTS AND TOTALS BASED ON RESPONDENTS

52 VALID CASES; 263 MISSING CASES

Table 104

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

GENERAL COMMENTS REGARDING DA FORM 3888-5 TEST

NURSING DISCHARGE SUMMARY

BY TYPE OF PROVIDER

	TYPE				
COMMENTS	IRN 1	PARA 2	WARD CLERK 3	PROFES-SIONAL 4	ROW TOTAL
3888-5+ KEEP	2	20	11	12	45
	4.4	44.4	24.4	26.7	56.3
	25.0	55.6	64.7	63.2	
	2.5	25.0	13.8	15.0	
3888-5+REDESIGN CMT	5	4	4	8	21
	23.8	19.0	19.0	38.1	26.3
	62.5	11.1	23.5	42.1	
	6.3	5.0	5.0	10.0	
3888-5+MULTIDISCIP	0	6	0	1	7
	.0	85.7	.0	14.3	8.8
	.0	16.7	.0	5.3	
	.0	7.5	.0	1.3	
3888-5-REDUNDANT	1	6	2	0	9
	11.1	66.7	22.2	.0	11.3
	12.5	16.7	11.8	.0	
	1.3	7.5	2.5	.0	
3888-5 MIS COMMENTS	0	1	0	1	2
	.0	50.0	.0	50.0	2.5
	.0	2.8	.0	5.3	
	.0	1.3	.0	1.3	
COLUMN TOTAL	8	36	17	19	80
	10.0	45.0	21.3	23.8	100.0

PERCENTS AND TOTALS BASED ON RESPONDENTS

80 VALID CASES; 235 MISSING CASES

Table 105

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

GENERAL COMMENTS REGARDING DA FORM 4256-1 TEST DOCTOR'S ORDER SHEET MEDICATION

AND DA FORM 4256-2 TEST DOCTOR'S ORDER SHEET NONMEDICATION

BY TYPE OF PROVIDER

COMMENTS	COUNT / ROW PCT / COL PCT / TAB PCT	TYPE IRN 1	PARA 2	WARD CLERK 3	PROFESSIONAL 4	ROW TOTAL
1 DR ORDER +GEN SAT		3	17	9	7	36
		8.3	47.2	25.0	19.4	37.5
		18.8	42.5	36.0	46.7	
		3.1	17.7	9.4	7.3	
2 DR ORD +SINGLE ACT		1	6	0	3	10
		10.0	60.0	.0	30.0	10.4
		6.3	15.0	.0	20.0	
		1.0	6.3	.0	3.1	
4 DR ORD-GEN-PAPERWRK		0	1	0	0	1
		.0	100.0	.0	.0	1.0
		.0	2.5	.0	.0	
		.0	1.0	.0	.0	
5 DR ORD-CONFUS-TIME		2	1	1	0	4
		50.0	25.0	25.0	.0	4.2
		12.5	2.5	4.0	.0	
		2.1	1.0	1.0	.0	
6 DR ORD-MISS ORDERS		2	4	1	0	7
		28.6	57.1	14.3	.0	7.3
		12.5	10.0	4.0	.0	
		2.1	4.2	1.0	.0	
7 DR ORD-STIL TRANSC		0	0	0	1	1
		.0	.0	.0	100.0	1.0
		.0	.0	.0	6.7	
		.0	.0	.0	1.0	
8 DR ORD-MISC PROBLEM		5	4	3	3	15
		33.3	26.7	20.0	20.0	15.6
		31.3	10.0	12.0	20.0	
		5.2	4.2	3.1	3.1	
COLUMN TOTAL		16	40	25	15	96
		16.7	41.7	26.0	15.6	100.0

Table 105

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

GENERAL COMMENTS REGARDING DA FORM 4256-1 TEST DOCTOR'S ORDER SHEET MEDICATION

AND DA FORM 4256-2 TEST DOCTOR'S ORDER SHEET NONMEDICATION

BY TYPE OF PROVIDER (CONTINUED)

	TYPE				
COMMENTS	COUNT / ROW PCT / COL PCT / TAB PCT	IRN 1	PARA 2	WARD CLERK 3	PROFES-SIONAL 4	ROW TOTAL
9		6	17	13	4	40
DR ORD 1-SHEET PREFR		15.0	42.5	32.5	10.0	41.7
		37.5	42.5	52.0	26.7	
		6.3	17.7	13.5	4.2	
10		1	0	2	0	3
DR ORD REDISN COMMNT		33.3	.0	66.7	.0	3.1
		0.3	.0	8.0	.0	
		1.0	.0	2.1	.0	
COLUMN TOTAL		16	40	25	15	96
		16.7	41.7	26.0	15.6	100.0

PERCENTS AND TOTALS BASED ON RESPONDENTS

96 VALID CASES; 219 MISSING CASES

Table 106

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

DA FORM 4677-1 TEST THERAPEUTIC DOCUMENTATION CARE PLAN NONMEDICATION

AND DA FORM 4678-1 TEST THERAPEUTIC DOCUMENTATION CARE PLAN MEDICATION

BY TYPE OF PROVIDER

COMMENTS	COUNT / ROW PCT / COL PCT / TAB PCT	IRN 1	PARA 2	WARD CLERK 3	PROFESSIONAL 4	ROW TOTAL
40		3	14	8	2	27
TDS+KEEP,NO CHANGES		11.1	51.9	29.6	7.4	27.8
		16.7	36.8	36.4	10.5	
		3.1	14.4	8.2	2.1	
41		8	15	6	13	42
TDS REDESIGN COMMNTS		19.0	35.7	14.3	31.0	43.3
		44.4	39.5	27.3	68.4	
		8.2	15.5	6.2	13.4	
42		1	2	4	1	8
TDS CODING ISSUES		12.5	25.0	50.0	12.5	8.2
		5.6	5.3	18.2	5.3	
		1.0	2.1	4.1	1.0	
43		3	7	3	1	14
TDS-OLD BETTER		21.4	50.0	21.4	7.1	14.4
		16.7	18.4	13.6	5.3	
		3.1	7.2	3.1	1.0	
44		8	2	1	3	14
TDS OVERPRINT COMMEN		57.1	14.3	7.1	21.4	14.4
		44.4	5.3	4.5	15.8	
		8.2	2.1	1.0	3.1	
COLUMN TOTAL		18	38	22	19	97
		18.6	39.2	22.7	19.6	100.0

PERCENTS AND TOTALS BASED ON RESPONDENTS

97 VALID CASES; 218 MISSING CASES

Table 107

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

GENERAL COMMENTS REGARDING INTEGRATED PROGRESS NOTES

BY TYPE OF PROVIDER

COMMENTS	COUNT / ROW PCT / COL PCT / TAB PCT	TYPE IRN 1	PARA 2	WARD CLERK 3	PROFES-SIONAL 4	ROW TOTAL
11		7	21	10	11	49
509+ GEN SATISFACT		14.3	42.9	20.4	22.4	62.8
		70.0	65.6	47.6	73.3	
		9.0	26.9	12.8	14.1	
12		0	1	2	2	5
509+IMPROVES COMMUN		.0	20.0	40.0	40.0	6.4
		.0	3.1	9.5	13.3	
		.0	1.3	2.6	2.6	
13		0	2	5	0	7
509+ KEEP		.0	28.6	71.4	.0	9.0
		.0	6.3	23.8	.0	
		.0	2.6	6.4	.0	
14		1	1	0	1	3
509- GEN PROBLEMS		33.3	33.3	.0	33.3	3.8
		10.0	3.1	.0	6.7	
		1.3	1.3	.0	1.3	
15		2	3	0	0	5
509-PARAPROF ENTRY		40.0	60.0	.0	.0	6.4
		20.0	9.4	.0	.0	
		2.6	3.8	.0	.0	
16		1	2	2	0	5
509-DECR DOCU,LEGAL		20.0	40.0	40.0	.0	6.4
		10.0	6.3	9.5	.0	
		1.3	2.6	2.6	.0	
17		1	2	0	1	4
509-MDS DONT LIKE		25.0	50.0	.0	25.0	5.1
		10.0	6.3	.0	6.7	
		1.3	2.6	.0	1.3	
	COLUMN TOTAL	10	32	21	15	78
		12.8	41.0	26.9	19.2	100.0

Table 107

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

GENERAL COMMENTS REGARDING INTEGRATED PROGRESS NOTES

BY TYPE OF PROVIDER (CONTINUED)

COMMENTS	COUNT / ROW PCT / COL PCT / TAB PCT	TYPE: IRN (1)	PARA (2)	WARD CLERK (3)	PROFESSIONAL (4)	ROW TOTAL
509-CONFUS,FRAGMNT	19	0	0	0	1	1
		.0	.0	.0	100.0	1.3
		.0	.0	.0	6.7	
		.0	.0	.0	1.3	
509-NOTES QUALITY	20	1	3	1	0	5
		20.0	60.0	20.0	.0	6.4
		10.0	9.4	4.8	.0	
		1.3	3.8	1.3	.0	
509-ID OF SOURCE	21	0	2	0	0	2
		.0	100.0	.0	.0	2.6
		.0	6.3	.0	.0	
		.0	2.6	.0	.0	
509 GO BACK TO SEP N	22	0	1	3	1	5
		.0	20.0	60.0	20.0	6.4
		.0	3.1	14.3	6.7	
		.0	1.3	3.8	1.3	
	COLUMN TOTAL	10	32	21	15	78
		12.8	41.0	26.9	19.2	100.0

PERCENTS AND TOTALS BASED ON RESPONDENTS

78 VALID CASES; 237 MISSING CASES

Table 108

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

CURRENT DUTY ASSIGNMENT

BY TYPE OF PROVIDER

H1	TYPE IRNS 1	PARA 2	ROW TOTAL
1 CLIN STAFF NURSE	39		39 38.6
2 CLIN HEAD NURSE	8		8 7.9
4 SPEC PRACTICES	4		4 4.0
6 CH-ASST CH NURSE	1		1 1.0
8 91A-AIDE		10	10 9.9
10 91C PRACT NRS		35	35 34.7
11 91F-PSYCH TECH		4	4 4.0
COLUMN TOTAL	52 51.5	49 48.5	101 100.0

NUMBER OF MISSING OBSERVATIONS = 32

Table 109

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

"ARE YOU A WARDMASTER?"

BY TYPE OF PROVIDER

		TYPE	
	COUNT	PARA	ROW TOTAL
		2	
H2			
1 YES	1	11	11
			22.4
2 NO	2	38	38
			77.6
	COLUMN TOTAL	49	49
		100.0	100.0

NUMBER OF MISSING OBSERVATIONS = 84

Table 110

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

PRIMARY INPATIENT NURSING UNIT

BY TYPE OF PROVIDER

H3	COUNT	TYPE IRNS 1	PARA 2	WARD CLERK 3	ROW TOTAL
1		11	10	1	22
SURG UNIT					20.8
2		5	5		10
PSYCH UNIT					9.4
3		7	9	1	17
MED UNIT					16.0
4			1	1	2
COMBINED MED SUR					1.9
5		5	6	1	12
PEDS UNIT					11.3
6		3	4	1	8
ALL ICU S					7.5
7		18	13	2	33
LED NEN POST PAR					31.1
9		1	1		2
OTHER					1.9
	COLUMN TOTAL	50 47.2	49 46.2	7 6.6	106 100.0

NUMBER OF MISSING OBSERVATIONS = 27

Table 111

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

NUMBER OF YEARS WORKED AS A REGISTERED NURSE

BY TYPE OF PROVIDER

H4 COUNT	TYPE IRNS 11	ROW TOTAL
1	7	7
		15.6
2	11	11
		24.4
3	1	1
		2.2
4	1	1
		2.2
5	1	1
		2.2
6	1	1
		2.2
7	2	2
		4.4
8	2	2
		4.4
10	3	3
		6.7
11	4	4
		8.9
12	5	5
		11.1
13	2	2
		4.4
16	1	1
		2.2
17	1	1
		2.2
18	1	1
		2.2
19	1	1
		2.2
20	1	1
		2.2
COLUMN TOTAL	45	45
	100.0	100.0

NUMBER OF MISSING OBSERVATIONS = 88

Table 112

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

CORPS AFFILIATION

BY TYPE OF PROVIDER

H5	COUNT	TYPE PROFESSIONAL (41)	ROW TOTAL
MC-CIV	3	17	17
			89.5
WD-PA	5	2	2
			10.5
COLUMN TOTAL		19	19
		100.0	100.0

NUMBER OF MISSING OBSERVATIONS = 114

Table 113

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

NUMBER OF YEARS WORKED WITH ARMY INPATIENT

MEDICAL RECORDS/DOCUMENTATION

BY TYPE OF PROVIDER

H6	TYPE IRNS 1	PARA 2	WARD CLERK 3	PROFES-SIONAL 4	ROW TOTAL
1	9	3	1		13
					11.4
2	13	11	2	1	27
					23.7
3	1	1		1	3
					2.6
4	4	1	2	3	10
					8.8
5	1	2		1	4
					3.5
6	3	3		3	9
					7.9
7	1	2		4	7
					6.1
8	1	4		3	8
					7.0
9	1	2		2	5
					4.4
10	2	3	1	1	7
					6.1
11	1	1			2
					1.8
12	4				4
					3.5
13	1	1			2
					1.8

Table 113

FORT .MPBELL

CLINICAL NURSING RECORDS STUDY

NUMBER OF YEARS WORKED WITH ARMY INPATIENT

MEDICAL RECORDS/DOCUMENTATION

BY TYPE OF PROVIDER (CONTINUED)

HE	COUNT	TYPE IRNS 1	PARA 2	WARD CLERK 3	PROFES-SIONAL 4	ROW TOTAL
	14	1	1			2
						1.8
	15	1	3			4
						3.5
	16	1	1			2
						1.8
	17	1				1
						.9
	18	1	1			2
						1.8
	19		1			1
						.9
	20				1	1
						.9
	COLUMN TOTAL	47	41	6	20	114
		41.2	36.0	5.3	17.5	100.0

NUMBER OF MISSING OBSERVATIONS = 19

Table 114

FORT CAMPBELL

CLINICAL NURSING RECORDS STUDY

FINAL GENERAL COMMENTS

BY TYPE OF PROVIDER

COMMENTS	TYPE: 1 IRN	2 PARA	3 WARD CLERK	4 PROFESSIONAL	ROW TOTAL
GEN+SYS CHG CMTS	5	14	3	8	30
	16.7	46.7	10.0	26.7	40.5
	50.0	41.2	33.3	38.1	
	6.8	18.9	4.1	10.8	
GEN -CMTS,OLD BETTR	1	3	2	0	6
	16.7	50.0	33.3	.0	8.1
	10.0	8.8	22.2	.0	
	1.4	4.1	2.7	.0	
OVERPRINT COMMENTS	1	5	1	0	7
	14.3	71.4	14.3	.0	9.5
	10.0	14.7	11.1	.0	
	1.4	6.8	1.4	.0	
REDESIGN COMMENTS	1	1	0	0	2
	50.0	50.0	.0	.0	2.7
	10.0	2.9	.0	.0	
	1.4	1.4	.0	.0	
SPECIFIC AREA PROBS	1	7	0	2	10
	10.0	70.0	.0	20.0	13.5
	10.0	20.6	.0	9.5	
	1.4	9.5	.0	2.7	
TDS WANT YELLOW HL	3	13	4	14	34
	8.8	38.2	11.8	41.2	45.9
	30.0	38.2	44.4	66.7	
	4.1	17.6	5.4	18.9	
COLUMN TOTAL	10	34	9	21	74
	13.5	45.9	12.2	28.4	100.0

PERCENTS AND TOTALS BASED ON RESPONDENTS

74 VALID CASES; 241 MISSING CASES

APPENDIX K

CNR Study Test Site Personnel Survey

Fitzsimons Army Medical Center

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

TYPE OF RESPONDENT

VALUE LABEL	VALUE	FREQUENCY	PERCENT	VALID PERCENT	CUM PERCENT
RNS	1	139	34.9	34.9	34.9
PARA	2	88	22.1	22.1	57.0
WARD CLERK	3	16	4.0	4.0	61.1
PROFES- SIONAL	4	155	38.9	38.9	100.0
	TOTAL	398	100.0	100.0	

VALID CASES 398 MISSING CASES 0

Table 2

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

"COMPARED TO THE OLD SYSTEM, I FEEL THE TEST FORMS SAVE ME NURSING DOCUMENTATION TIME" BY TYPE OF PROVIDER

A1 / COUNT	TYPE: RNS (1)	PARA (2)	ROW TOTAL
1 STRONGLY AGREE	62	39	101 45.1
2 AGREE	57	35	92 42.0
3 DISAGREE	7	13	20 9.1
4 STRONGLY DISAGRE	6		6 2.7
COLUMN TOTAL	132 60.3	87 39.7	219 100.0

NUMBER OF MISSING OBSERVATIONS = 179

Table 3

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

"COMPARED TO THE OLD SYSTEM, I FEEL THE TEST FORMS HELP AVOID WRITING SAME INFORMATION SEVERAL PLACES"

BY TYPE OF PROVIDER

A2	TYPE			
COUNT	RNS (1)	PARA (2)	WARD CLERK (3)	ROW TOTAL
1 STRONGLY AGREE	62	38	3	103
				44.2
2 AGREE	55	38	7	100
				42.9
3 DISAGREE	5	10	4	19
				8.2
4 STRONGLY DISAGREE	9	1	1	11
				4.7
COLUMN TOTAL	131	87	15	233
	56.2	37.3	6.4	100.0

NUMBER OF MISSING OBSERVATIONS = 165

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

"COMPARED TO THE OLD SYSTEM, I FEEL THE TEST FORMS IMPROVE COMMUNICATIONS ABOUT THE PATIENT AMONG NURSING PERSONNEL"

BY TYPE OF PROVIDER

A3	COUNT / TYPE	IRNS 11	PARA 21	ROW TOTAL
STRONGLY AGREE	1	34	21	55
				25.0
AGREE	2	68	48	116
				52.7
DISAGREE	3	24	16	40
				18.2
STRONGLY DISAGREE	4	7	2	9
				4.1
	COLUMN TOTAL	133	87	220
		60.5	39.5	100.0

NUMBER OF MISSING OBSERVATIONS = 178

Table 5

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

"COMPARED TO THE OLD SYSTEM, I FEEL THE TEST FORMS IMPROVE COMMUNICATIONS ABOUT THE PATIENT BETWEEN NURSING AND OTHER HEALTH CARE PROFESSIONALS"

BY TYPE OF PROVIDER

A4	COUNT	TYPE IRNS 11	TYPE PARA 21	ROW TOTAL
STRONGLY AGREE	1	40	25	65
				29.4
AGREE	2	60	44	104
				47.1
DISAGREE	3	27	15	43
				19.5
STRONGLY DISAGRE	4	6	3	9
				4.1
	COLUMN TOTAL	133	88	221
		60.2	39.8	100.0

NUMBER OF MISSING OBSERVATIONS = 177

Table 6

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

"COMPARED TO THE OLD SYSTEM, I FEEL THE TEST FORMS ENCOURAGE ME TO USE THE NURSING PROCESS"

BY TYPE OF PROVIDER

A5	COUNT \ TYPE	RNS	ROW TOTAL
		11	
1 STRONGLY AGREE	1	21	21
			16.0
2 AGREE	2	66	66
			50.4
3 DISAGREE	3	37	37
			28.2
4 STRONGLY DISAGREE	4	7	7
			5.3
	COLUMN TOTAL	131	131
		100.0	100.0

NUMBER OF MISSING OBSERVATIONS = 267

Table 7

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

"COMPARED TO THE OLD SYSTEM, I FEEL THE TEST FORMS ARE EASIER TO USE"

BY TYPE OF PROVIDER

A6	COUNT	TYPE: RNS (1)	PARA (2)	WARD CLERK (3)	ROW TOTAL
1 STRONGLY AGREE		47	31	3	81
					34.8
2 AGREE		66	45	8	119
					51.1
3 DISAGREE		16	8	1	25
					10.7
4 STRONGLY DISAGRE		4	1	3	8
					3.4
	COLUMN TOTAL	133	85	15	233
		57.1	36.5	6.4	100.0

NUMBER OF MISSING OBSERVATIONS = 165

Table 8

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

"COMPARED TO THE OLD SYSTEM, I FEEL THE TEST FORMS SHOULD HAVE BEEN A MORE DRASTIC CHANGE"

BY TYPE OF PROVIDER

A7	TYPE 1 RNS	2 PARA	3 WARD CLERK	ROW TOTAL
1 STRONGLY AGREE	11	5	2	18 7.9
2 AGREE	31	22	3	56 24.7
3 DISAGREE	73	51	9	133 58.6
4 STRONGLY DISAGREE	13	6	1	20 8.8
COLUMN TOTAL	128 56.4	84 37.0	15 6.6	227 100.0

NUMBER OF MISSING OBSERVATIONS = 171

Table 9

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

"COMPARED TO THE OLD SYSTEM, I FEEL THE TEST FORMS

ARE A DEFINITE IMPROVEMENT"

BY TYPE OF PROVIDER

AB	TYPE COUNT	1 RNS	2 PARA	3 WARD CLERK	ROW TOTAL
1		47	27	3	77
STRONGLY AGREE					32.9
2		67	49	7	123
AGREE					52.6
3		15	8	5	28
DISAGREE					12.0
4		4	2		6
STRONGLY DISAGREE					2.6
	COLUMN TOTAL	133 56.8	86 36.8	15 6.4	234 100.0

NUMBER OF MISSING OBSERVATIONS = 164

Table .0

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

"COMPARED TO THE OLD SYSTEM, I FEEL THE TEST FORMS PROVIDE ME A BETTER PICTURE OF WHAT IS HAPPENING TO THE PATIENT"

BY TYPE OF PROVIDER

A9	COUNT	TYPE RNS (1)	PARA (2)	ROW TOTAL
1	STRONGLY AGREE	30	19	49 22.5
2	AGREE	71	50	121 55.5
3	DISAGREE	27	16	43 19.7
4	STRONGLY DISAGRE	4	1	5 2.3
	COLUMN TOTAL	132 60.6	86 39.4	218 100.0

NUMBER OF MISSING OBSERVATIONS = 180

Table 11

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

"COMPARED TO THE OLD SYSTEM, I FEEL THE TEST FORMS REDUCE THE AMOUNT OF PAPERWORK I HAVE TO DO"

BY TYPE OF PROVIDER

A10	TYPE COUNT	IRNS 1	PARA 2	WARD CLERK 3	ROW TOTAL
1 STRONGLY AGREE	1	57	35	5	97 41.8
2 AGREE	2	47	30	5	82 35.3
3 DISAGREE	3	20	16	4	40 17.2
4 STRONGLY DISAGRE	4	8	3	2	13 5.6
	COLUMN TOTAL	132 56.9	84 36.2	16 6.9	232 100.0

NUMBER OF MISSING OBSERVATIONS = 166

Table 12

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

"COMPARED TO THE OLD SYSTEM, I FEEL THE TEST FORMS HAVE IMPROVED THE QUALITY OF DOCUMENTATION ON MY NURSING UNIT"

BY TYPE OF PROVIDER

All	TYPE COUNT	IRNS	PARA	ROW TOTAL
		11	21	
STRONGLY AGREE	1	24	21	45
				21.1
AGREE	2	63	40	103
				48.4
DISAGREE	3	36	20	56
				26.3
STRONGLY DISAGRE	4	6	3	9
				4.2
	COLUMN TOTAL	129	84	213
		60.6	39.4	100.0

NUMBER OF MISSING OBSERVATIONS = 185

Table 13

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

"THE NUMBER OF NURSING HISTORY QUESTIONS IS ADEQUATE"

BY TYPE OF PROVIDER

B1	TYPE		
COUNT	RNS	PARA	ROW TOTAL
	11	21	
1 STRONGLY AGREE	27	13	40
			19.7
2 AGREE	74	56	130
			64.0
3 DISAGREE	20	12	32
			15.8
4 STRONGLY DISAGRE	1		1
			.5
COLUMN TOTAL	122	81	203
	60.1	39.9	100.0

NUMBER OF MISSING OBSERVATIONS = 195

Table 14

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

"THE CONTENT OF THE NURSING HISTORY QUESTIONS IS AS THOROUGH AS I NEED THEM TO BE"

BY TYPE OF PROVIDER

B2	TYPE IRNS 11	PARA 21	ROW TOTAL
1 STRONGLY AGREE	25	11	36
			17.6
2 AGREE	67	51	118
			57.8
3 DISAGREE	30	18	48
			23.5
4 STRONGLY DISAGREE	2		2
			1.0
COLUMN TOTAL	124 60.8	80 39.2	204 100.0

NUMBER OF MISSING OBSERVATIONS = 194

Table 15

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

"ON MY NURSING UNIT THE BLOCK FOR PATIENT'S PERSONAL ARTICLES AND VALUABLES IS HELPFUL"

BY TYPE OF PROVIDER

B3	COUNT / TYPE	IRNS 11	PARA 21	WARD CLERK 31	ROW TOTAL
1		20	17	3	40
STRONGLY AGREE					18.4
2		57	46	7	110
AGREE					50.7
3		35	19	3	57
DISAGREE					26.3
4		9		1	10
STRONGLY DISAGREE					4.6
	COLUMN TOTAL	121	82	14	217
		55.8	37.8	6.5	100.0

NUMBER OF MISSING OBSERVATIONS = 181

Table 16

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

"ON MY NURSING UNIT MOST NURSING HISTORIES ARE DONE BY NON-RN/ANC PERSONNEL."

BY TYPE OF PROVIDER

B4	COUNT	TYPE RNS 1	PARA 2	WARD CLERK 3	ROW TOTAL
1 STRONGLY AGREE		13	13	4	30 13.6
2 AGREE		24	24	5	53 24.1
3 DISAGREE		61	38	3	102 46.4
4 STRONGLY DISAGRE		27	8		35 15.9
	COLUMN TOTAL	125 56.8	83 37.7	12 5.5	220 100.0

NUMBER OF MISSING OBSERVATIONS = 178

Table 17

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

"ON MY NURSING UNIT ALL NURSING ASSESSMENTS ARE

DONE BY RNs AND ANCs"

BY TYPE OF PROVIDER

B5	COUNT	TYPE 1 RNS	2 PARA	3 WARD CLERK	ROW TOTAL
1 STRONGLY AGREE		62	22	5	89
					39.4
2 AGREE		42	31	5	78
					34.5
3 DISAGREE		22	27	2	51
					22.6
4 STRONGLY DISAGRE		3	5		8
					3.5
	COLUMN TOTAL	129	85	12	226
		57.1	37.6	5.3	100.0

NUMBER OF MISSING OBSERVATIONS = 172

Table 18

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

"ON MY NURSING UNIT AN OVERPRINT IS USED FOR THE ASSESSMENT"

BY TYPE OF PROVIDER

B6	COUNT	TYPE IRNS 11	ROW TOTAL
STRONGLY AGREE	1	31	31 25.4
AGREE	2	43	43 35.2
DISAGREE	3	35	35 28.7
STRONGLY DISAGREE	4	13	13 10.7
	COLUMN TOTAL	122 100.0	122 100.0

NUMBER OF MISSING OBSERVATIONS = 276

Table 19

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

"ON MY NURSING UNIT WE OFTEN USE THE HISTORY

AND ASSESSMENT CONTINUATION SHEET"

BY TYPE OF PROVIDER

B7	COUNT / TYPE	IRNS 1	PARA 2	WARD CLERK 3	ROW TOTAL
1	STRONGLY AGREE	22	4	1	27
					12.4
2	AGREE	22	45	5	72
					33.0
3	DISAGREE	53	27	5	85
					39.0
4	STRONGLY DISAGRE	28	4	2	34
					15.6
	COLUMN TOTAL	125	80	13	218
		57.3	36.7	6.0	100.0

NUMBER OF MISSING OBSERVATIONS = 180

Table 20

FITZSIMONS ARMY MEDICAL CENTER

CLINIC NURSING RECORDS STUDY

"OVERPRINTING THE ASSESSMENT CATEGORIES FROM THE

STANDARDS OF NURSING PRACTICE (DA PAM 40-5)

IS HELPFUL TO ME"

BY TYPE OF PROVIDER

BE	COUNT	TYPE RNS 11	ROW TOTAL
STRONGLY AGREE	1	38	38 34.5
AGREE	2	61	61 55.5
DISAGREE	3	8	8 7.3
STRONGLY DISAGREE	4	3	3 2.7
	COLUMN TOTAL	110 100.0	110 100.0

NUMBER OF MISSING OBSERVATIONS = 288

Table 21

FITZSIMONS ARMY MEDICAL CENTER

CLINIC NURSING RECORDS STUDY

"OVERPRINTING THE ASSESSMENT CATEGORIES FROM THE STANDARDS OF NURSING PRACTICE (DA PAM 40-5) HAS INCREASED MY USE OF THE CATEGORIES"

BY TYPE OF PROVIDER

B9	COUNT	TYPE RNS 11	ROW TOTAL
STRONGLY AGREE	1	31	31 28.7
AGREE	2	57	57 52.8
DISAGREE	3	17	17 15.7
STRONGLY DISAGREE	4	3	3 2.8
	COLUMN TOTAL	108 100.0	108 100.0

NUMBER OF MISSING OBSERVATIONS = 290

Table 22

FITZSIMONS ARMY MEDICAL CENTER

CLINIC NURSING RECORDS STUDY

"OVERPRINTING THE ASSESSMENT CATEGORIES FROM THE STANDARDS OF NURSING PRACTICE (DA PAM 40-5) SHOULD BE CONTINUED"

BY TYPE OF PROVIDER

		TYPE	
	COUNT	IRNS	ROW TOTAL
		11	
B10			
1		41	41
STRONGLY AGREE			38.7
2		57	57
AGREE			53.8
3		6	6
DISAGREE			5.7
4		2	2
STRONGLY DISAGRE			1.9
COLUMN TOTAL		106	106
		100.0	100.0

NUMBER OF MISSING OBSERVATIONS = 292

Table 23

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

"I LIKE THE IDEA OF THE NURSING HISTORY AND ASSESSMENT, IF COMPLETED ON ADMISSION, SERVING AS THE ADMISSION NURSING NOTE"

BY TYPE OF PROVIDER

B11	COUNT	TYPE IRNS 11	ROW TOTAL
STRONGLY AGREE	1	87	87
			66.9
AGREE	2	38	38
			29.2
DISAGREE	3	4	4
			3.1
STRONGLY DISAGRE	4	1	1
			.8
	COLUMN TOTAL	130	130
		100.0	100.0

NUMBER OF MISSING OBSERVATIONS = 268

Table 24

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

"OVERPRINTING THE NURSING DIAGNOSES ONTO THE CARE PLAN

IS HELPFUL TO ME"

BY TYPE OF PROVIDER

B12	COUNT	TYPE IRNS 11	ROW TOTAL
STRONGLY AGREE	1	57	57 47.9
AGREE	2	52	52 43.7
DISAGREE	3	8	8 6.7
STRONGLY DISAGRE	4	2	2 1.7
	COLUMN TOTAL	119 100.0	119 100.0

NUMBER OF MISSING OBSERVATIONS = 279

Table 25

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

"OVERPRINTING THE NURSING DIAGNOSES ONTO THE CARE PLAN HAS INCREASED MY USE OF THE DIAGNOSES"

BY TYPE OF PROVIDER

B13	COUNT / TYPE: RNS	ROW TOTAL
1 STRONGLY AGREE	48	48
		41.0
2 AGREE	54	54
		46.2
3 DISAGREE	13	13
		11.1
4 STRONGLY DISAGRE	2	2
		1.7
COLUMN TOTAL	117	117
	100.0	100.0

NUMBER OF MISSING OBSERVATIONS = 281

Table 26

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

"OVERPRINTING THE NURSING DIAGNOSES ONTO THE CARE PLAN SHOULD BE CONTINUED"

BY TYPE OF PROVIDER

B14	TYPE RNS	ROW TOTAL
1 STRONGLY AGREE	59 50.0	59 50.0
2 AGREE	52 44.1	52 44.1
3 DISAGREE	3 2.5	3 2.5
4 STRONGLY DISAGREE	4 3.4	4 3.4
COLUMN TOTAL	118 100.0	118 100.0

NUMBER OF MISSING OBSERVATIONS = 280

Table 27

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

"I READ THE NURSING CARE PLAN TO LEARN THE OVERALL GOALS FOR THE PATIENT"

BY TYPE OF PROVIDER

B15	TYPE PARA 2	ROW TOTAL
1 STRONGLY AGREE	15	15 17.6
2 AGREE	55	55 64.7
3 DISAGREE	12	12 14.1
4 STRONGLY DISAGREE	3	3 3.5
COLUMN TOTAL	85 100.0	85 100.0

NUMBER OF MISSING OBSERVATIONS = 313

Table 28

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

"OTHER THAN THE PATIENT IDENTIFICATION STAMP, I HAVE COMPLETED SOME PORTIONS OF THE NURSING DISCHARGE SUMMARY FOR THE NURSES"

BY TYPE OF PROVIDER

C1	TYPE COUNT PARA (2)	WARD CLERK (3)	ROW TOTAL
1 STRONGLY AGREE	9	1	10 10.1
2 AGREE	30	3	33 33.3
3 DISAGREE	35	9	44 44.4
4 STRONGLY DISAGREE	10	2	12 12.1
COLUMN TOTAL	84 84.8	15 15.2	99 100.0

NUMBER OF MISSING OBSERVATIONS = 299

Table 29

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORD STUDY

"OTHER THAN THE PATIENT IDENTIFICATION STAMP, THE ENTIRE NURSING DISCHARGE SUMMARY IS COMPLETED ONLY BY AN RN/ANC ON MY NURSING UNIT"

BY TYPE OF PROVIDER

C2	COUNT / TYPE	PARA 21	WARD CLERK 31	ROW TOTAL
STRONGLY AGREE	1	14	5	20
				20.2
AGREE	2	32	5	37
				37.4
DISAGREE	3	33	3	36
				36.4
STRONGLY DISAGRE	4	6		6
				6.1
	COLUMN TOTAL	85	14	99
		85.9	14.1	100.0

NUMBER OF MISSING OBSERVATIONS = 299

Table 30

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

"NURSING DISCHARGE SUMMARY (DA FORM 3888-5 TEST) - ELEMENTS ON THE FORM ARE THOSE I WOULD INCLUDE IN A DISCHARGE NURSING NOTE"

BY TYPE OF PROVIDER

C3	COUNT	TYPE RNS	ROW TOTAL
STRONGLY AGREE	1	42	42 37.2
AGREE	2	61	61 54.0
DISAGREE	3	6	6 5.3
STRONGLY DISAGREE	4	4	4 3.5
	COLUMN TOTAL	113 100.0	113 100.0

NUMBER OF MISSING OBSERVATIONS = 285

Table 31

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

"NURSING DISCHARGE SUMMARY (DA FORM 3888-5 TEST) - I LIKE TO HAVE THE DISCHARGE SUMMARY SERVE AS THE NURSING DISCHARGE NOTE"

BY TYPE OF PROVIDER

C4	COUNT / TYPE: IRNS	ROW TOTAL
1 STRONGLY AGREE	60	60 51.7
2 AGREE	51	51 44.0
3 DISAGREE	3	3 2.6
4 STRONGLY DISAGRE	2	2 1.7
COLUMN TOTAL	116 100.0	116 100.0

NUMBER OF MISSING OBSERVATIONS = 282

Table 32

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

"NURSING DISCHARGE SUMMARY (DA FORM 3888-5 TEST) -

IT IS HELPFUL TO HAVE A COPY FOR THE PATIENT"

BY TYPE OF PROVIDER

C5	COUNT	TYPE RNS	ROW TOTAL
1 STRONGLY AGREE		54 47.0	54 47.0
2 AGREE		53 46.1	53 46.1
3 DISAGREE		5 4.3	5 4.3
4 STRONGLY DISAGRE		3 2.6	3 2.6
	COLUMN TOTAL	115 100.0	115 100.0

NUMBER OF MISSING OBSERVATIONS = 283

Table 33

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

"NURSING DISCHARGE SUMMARY (DA FORM 3888-5 TEST) - IT IS IMPORTANT FOR A NURSING SUMMARY TO APPEAR IN THE OUTPATIENT RECORD"

BY TYPE OF PROVIDER

C6	COUNT	TYPE IRNS 11	ROW TOTAL
1 STRONGLY AGREE	1	36	36 32.1
2 AGREE	2	57	57 50.9
3 DISAGREE	3	15	15 13.4
4 STRONGLY DISAGREE	4	4	4 3.6
	COLUMN TOTAL	112 100.0	112 100.0

NUMBER OF MISSING OBSERVATIONS = 286

Table 34

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

"NURSING DISCHARGE SUMMARY (DA FORM 3888-5 TEST) - THE NURSING DISCHARGE SUMMARY FORM NEEDS TO BE KEPT IN THE SYSTEM"

BY TYPE OF PROVIDER

C7	COUNT / TYPE: IRNS	ROW TOTAL
1 STRONGLY AGREE	44	44
		38.6
2 AGREE	56	56
		49.1
3 DISAGREE	9	9
		7.9
4 STRONGLY DISAGRE	5	5
		4.4
COLUMN TOTAL	114	114
	100.0	100.0

NUMBER OF MISSING OBSERVATIONS = 284

Table 35

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

"NURSING DISCHARGE SUMMARY (DA FORM 3888-5 TEST) - DISCHARGE SUMMARIES SHOULD BE IN A MULTIDISCIPLINARY FORMAT SO PHYSICIANS AND OTHER HEALTH CARE PROVIDERS COULD MAKE APPROPRIATE NOTATIONS"

BY TYPE OF PROVIDER

		TYPE	
	COUNT	IRNS	ROW TOTAL
		11	
C8			
1 STRONGLY AGREE	1	43	43
			36.8
AGREE	2	56	56
			47.9
DISAGREE	3	14	14
			12.0
STRONGLY DISAGRE	4	4	4
			3.4
	COLUMN TOTAL	117	117
		100.0	100.0

NUMBER OF MISSING OBSERVATIONS = 281

Table 36

FITZSIMONS ARMY MEDICAL CENTER

CINICAL NURSING RECORDS STUDY

"DOCTOR'S ORDERS MEDICATION/DOCTOR'S ORDERS NONMEDICATION

(DA FORM 4256-1 TEST; DA FORM 4256-2 TEST) -

WE FREQUENTLY USE THE BUFF COPY ON

NURSING UNIT"

BY TYPE OF PROVIDER

D1	COUNT	TYPE RNS 1	PARA 2	WARD CLERK 3	ROW TOTAL
1 STRONGLY AGREE	1	16	9	2	27
					12.1
2 AGREE	2	30	27	1	58
					26.0
3 DISAGREE	3	32	33	7	72
					32.3
4 STRONGLY DISAGRE	4	50	11	5	66
					29.6
	COLUMN TOTAL	128	80	15	223
		57.4	35.9	6.7	100.0

NUMBER OF MISSING OBSERVATIONS = 175

Table 37

FITZSIMONS ARMY MEDICAL CENTER

CINICAL NURSING RECORDS STUDY

"DOCTOR'S ORDERS MEDICATION/DOCTOR'S ORDERS NONMEDICATION

(DA FORM 4256-1 TEST; DA FORM 4256-2 TEST) - I LIKE

NOT HAVING TO RECOPY SOME SINGLE ACTION ORDERS

ONTO THE THERAPEUTIC DOCUMENTATION CARE

PLAN"

BY TYPE OF PROVIDER

D2	COUNT	TYPE 1 RNS	11 PARA	21 WARD CLERK	31	ROW TOTAL
1		77	39	3		119
STRONGLY AGREE						52.9
2		38	29	8		75
AGREE						33.3
3		11	9	2		22
DISAGREE						9.8
4		3	4	2		9
STRONGLY DISAGRE						4.0
	COLUMN TOTAL	129 57.3	81 36.0	15 6.7		225 100.0

NUMBER OF MISSING OBSERVATIONS = 173

Table 38

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

"DURING THE TEST PERIOD, HOW OFTEN DID YOU USE THE NURSING HISTORY AND ASSESSMENT TO LEARN ABOUT NURSING ACTIVITIES AND THE PATIENT'S CONDITION?"

BY TYPE OF PROVIDER

X1A	COUNT	TYPE PROFESSIONAL 41	ROW TOTAL
EVERY PNT	1	8	8 5.4
MOST PNTS	2	43	43 29.3
RARELY	3	63	63 42.9
NEVER	4	33	33 22.4
	COLUMN TOTAL	147 100.0	147 100.0

NUMBER OF MISSING OBSERVATIONS = 251

Table 39

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

"DURING THE TEST PERIOD, HOW OFTEN DID YOU USE THE NURSING CARE PLAN TO LEARN ABOUT NURSING ACTIVITY AND THE PATIENT'S CONDITION?"

BY TYPE OF PROVIDER

X1B	COUNT \ TYPE	PROFESSIONAL	ROW TOTAL
		1	
EVERY PNT	1	3	3
			2.0
MOST PNTS	2	11	11
			7.4
RARELY	3	60	60
			40.5
NEVER	4	74	74
			50.0
	COLUMN TOTAL	148	148
		100.0	100.0

NUMBER OF MISSING OBSERVATIONS = 250

Table 40

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

"DURING THE TEST PERIOD, HOW OFTEN DID YOU USE THE NURSING DISCHARGE SUMMARY TO LEARN ABOUT NURSING ACTIVITIES AND THE PATIENT'S CONDITION?"

BY TYPE OF PROVIDER

X1C	COUNT / TYPE	PROFESSIONAL (41)	ROW TOTAL
EVERY PNT	1	2	2
			1.4
MOST PNTS	2	10	10
			6.8
RARELY	3	59	59
			40.4
NEVER	4	75	75
			51.4
	COLUMN TOTAL	146	146
		100.0	100.0

NUMBER OF MISSING OBSERVATIONS = 252

Table 41

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

"DURING THE TEST PERIOD, HOW OFTEN DID YOU USE

THE THERAPEUTIC DOCUMENTATION CARE PLAN,

NONMEDICATION?"

BY TYPE OF PROVIDER

X1D	COUNT	TYPE PROFESSIONAL 41	ROW TOTAL
EVERY PNT	1	18	18 12.2
MOST PNTS	2	45	45 30.4
RARELY	3	53	53 35.8
NEVER	4	32	32 21.6
	COLUMN TOTAL	148 100.0	148 100.0

NUMBER OF MISSING OBSERVATIONS = 250

Table 42

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

"DURING THE TEST PERIOD, HOW OFTEN DID YOU USE THE THERAPEUTIC DOCUMENTATION CARE PLAN, MEDICATION?"

BY TYPE OF PROVIDER

		TYPE	
	COUNT	PROFESSIONAL	ROW TOTAL
		41	
X1E			
1 EVERY ENT	1	35	35
			23.6
2 MOST ENTS	2	42	42
			28.4
3 RARELY	3	43	43
			29.1
4 NEVER	4	28	28
			18.9
	COLUMN TOTAL	148	148
		100.0	100.0

NUMBER OF MISSING OBSERVATIONS = 250

Table 43

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

"DURING THE TEST PERIOD, HOW OFTEN DID YOU USE THE TPR GRAPHIC?"

BY TYPE OF PROVIDER

X1F	COUNT	TYPE PROFESSIONAL 41	ROW TOTAL
EVERY PNT	1	82	82 / 56.6
MOST PNTS	2	30	30 / 20.7
RARELY	3	19	19 / 13.1
NEVER	4	14	14 / 9.7
	COLUMN TOTAL	145 / 100.0	145 / 100.0

NUMBER OF MISSING OBSERVATIONS = 253

Table 44

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

"DURING THE TEST PERIOD, HOW OFTEN DID YOU USE THE PROGRESS NOTES?"

BY TYPE OF PROVIDER

		TYPE	
	COUNT	PROFESSIONAL	ROW TOTAL
		41	
XIG			
1 EVERY PNT	1	61	61
			40.9
2 MOST PNTS	2	43	43
			28.9
3 RARELY	3	34	34
			22.8
4 NEVER	4	11	11
			7.4
	COLUMN TOTAL	149	149
		100.0	100.0

NUMBER OF MISSING OBSERVATIONS = 249

Table 45

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

"DURING THE TEST PERIOD, HOW OFTEN DID YOU USE THE OTHER FORMS TO REVIEW NURSING CARE?"

BY TYPE OF PROVIDER

X1H	COUNT / TYPE: PROFESSIONAL (4)	ROW TOTAL
1 EVERY PNT	2	2 / 10.0
3 RARELY	3	3 / 15.0
4 NEVER	15	15 / 75.0
COLUMN TOTAL	20 / 100.0	20 / 100.0

NUMBER OF MISSING OBSERVATIONS = 378

Table 46

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

"PRIOR TO THE TEST PERIOD, HOW OFTEN HAD YOU USED THE NURSING HISTORY AND ASSESSMENT TO LEARN ABOUT NURSING ACTIVITIES AND THE PATIENT'S CONDITION?"

BY TYPE OF PROVIDER

X3A	COUNT	TYPE PROFESSIONAL 41	ROW TOTAL
EVERY PNT	1	8	8
			5.7
MOST PNTS	2	33	33
			23.6
RARELY	3	61	61
			43.6
NEVER	4	38	38
			27.1
	COLUMN TOTAL	140	140
		100.0	100.0

NUMBER OF MISSING OBSERVATIONS = 258

Table 47

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

"PRIOR TO THE TEST PERIOD, HOW OFTEN HAD YOU USED THE NURSING CARE PLAN TO LEARN ABOUT NURSING ACTIVITIES AND THE PATIENT'S CONDITION?"

BY TYPE OF PROVIDER

X3B	COUNT	TYPE 1 PROFESSIONAL 4	ROW TOTAL
1 EVERY PNT	1	3	3
			2.1
2 MOST PNTS	2	9	9
			6.4
3 RARELY	3	56	56
			40.0
4 NEVER	4	72	72
			51.4
	COLUMN TOTAL	140	140
		100.0	100.0

NUMBER OF MISSING OBSERVATIONS = 258

Table 48

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

"PRIOR TO THE TEST PERIOD, HOW OFTEN HAD YOU USED THE NURSING DISCHARGE SUMMARY TO LEARN ABOUT NURSING ACTIVITIES AND THE PATIENT'S CONDITION?"

BY TYPE OF PROVIDER

		TYPE	
	COUNT	PROFES-SIONAL	ROW TOTAL
		41	
X3C			
2		12	12
MOST PNTS			8.6
3		55	55
RARELY			39.6
4		72	72
NEVER			51.8
	COLUMN TOTAL	139	139
		100.0	100.0

NUMBER OF MISSING OBSERVATIONS = 259

Table 49

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

"PRIOR TO THE TEST PERIOD, HOW OFTEN HAD YOU USED THE THERAPEUTIC DOCUMENTATION CARE PLAN, NONMEDICATION?"

BY TYPE OF PROVIDER

X30	COUNT	TYPE PROFESSIONAL 41	ROW TOTAL
EVERY PNT	1	12	12
			8.6
MOST PNTS	2	36	36
			25.9
RARELY	3	53	53
			38.1
NEVER	4	38	38
			27.3
	COLUMN TOTAL	139	139
		100.0	100.0

NUMBER OF MISSING OBSERVATIONS = 259

Table 50

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

"PRIOR TO THE TEST PERIOD, HOW OFTEN HAD YOU USED THE THERAPEUTIC DOCUMENTATION CARE PLAN, MEDICATION?"

BY TYPE OF PROVIDER

X3E	COUNT	TYPE PROFESSIONAL 4	ROW TOTAL
EVERY PNT	1	27	27
			19.4
MOST PNTS	2	40	40
			28.8
RARELY	3	42	42
			30.2
NEVER	4	30	30
			21.6
	COLUMN TOTAL	139	139
		100.0	100.0

NUMBER OF MISSING OBSERVATIONS = 259

Table 51

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

"PRIOR TO THE TEST PERIOD, HOW OFTEN HAD YOU USED THE TPR GRAPHIC?"

BY TYPE OF PROVIDER

X3F	COUNT	TYPE PROFES- SIONAL 4	ROW TOTAL
EVERY PNT	1	77	77 55.0
MOST PNTS	2	29	29 20.7
RARELY	3	20	20 14.3
NEVER	4	14	14 10.0
	COLUMN TOTAL	140 100.0	140 100.0

NUMBER OF MISSING OBSERVATIONS = 258

Table 52

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

"PRIOR TO THE TEST PERIOD, HOW OFTEN HAD YOU USED THE NURSING NOTES?"

BY TYPE OF PROVIDER

X36	COUNT	TYPE PROFESSIONAL 4	ROW TOTAL
EVERY PNT	1	30	30 21.6
MOST PNTS	2	37	37 26.6
RARELY	3	49	49 35.3
NEVER	4	23	23 16.5
	COLUMN TOTAL	139 100.0	139 100.0

NUMBER OF MISSING OBSERVATIONS = 259

Table 53

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

"PRIOR TO THE TEST PERIOD, HOW OFTEN DID YOU USE OTHER FORMS TO REVIEW NURSING CARE?"

BY TYPE OF PROVIDER

X3H	COUNT	TYPE: PROFESSIONAL (4)	ROW TOTAL
EVERY PNT	1	1	1
			4.3
MOST PNTS	2	1	1
			4.3
RARELY	3	4	4
			17.4
NEVER	4	17	17
			73.9
	COLUMN TOTAL	23	23
		100.0	100.0

NUMBER OF MISSING OBSERVATIONS = 375

Table 54

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

"DOCTOR'S ORDERS MEDICATION/DOCTOR'S ORDERS NONMEDICATION

(DA FORM 4256-1 TEST; DA FORM 4256-2 TEST) - HAVING

TWO SEPARATE ORDER SHEETS CAUSED MINIMAL

DIFFICULTIES FOR ME"

BY TYPE OF PROVIDER

D3	TYPE COUNT	IRNS 1	PARA 2	WARD CLERK 3	PROFES-SIONAL 4	ROW TOTAL
1 STRONGLY AGREE	1	44	34	4	21	103 27.7
AGREE	2	54	39	8	48	149 40.1
DISAGREE	3	23	11	1	39	74 19.9
4 STRONGLY DISAGRE	4	13	1	2	30	46 12.4
	COLUMN TOTAL	134 36.0	85 22.8	15 4.0	138 37.1	372 100.0

NUMBER OF MISSING OBSERVATIONS = 26

Table 55

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

"DOCTOR'S ORDERS MEDICATION/DOCTOR'S ORDERS NONMEDICATION

(DA FORM 4256-1 TEST; DA FORM 4256-2 TEST) - ORDERS

SHOULD CONTINUE TO REMAIN SEPARATED ON COLOR

CODED MEDICATION AND NONMEDICATION SHEETS"

BY TYPE OF PROVIDER

D4	COUNT / TYPE	IRNS (1)	PARA (2)	WARD CLERK (3)	PROFESSIONAL (4)	ROW TOTAL
1	STRONGLY AGREE	64	42	8	21	135
						36.4
2	AGREE	42	38	6	52	138
						37.2
3	DISAGREE	12	5		27	44
						11.9
4	STRONGLY DISAGRE	14		2	38	54
						14.6
	COLUMN TOTAL	132	85	16	138	371
		35.6	22.9	4.3	37.2	100.0

NUMBER OF MISSING OBSERVATIONS = 27

Table 56

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

"DOCTOR'S ORDERS MEDICATION/DOCTOR'S ORDERS NONMEDICATION (DA FORM 4256-1 TEST; DA FORM 4256-2 TEST) - PRIOR TO THE TEST PERIOD, IF UNFAMILIAR WITH A PATIENT, I MOST OFTEN DETERMINED CURRENT MEDICATION(S) BY . . ."

BY TYPE OF PROVIDER

D6	COUNT / TYPE	PROFESSIONAL (41)	ROW TOTAL
REVIEW ALL DR OR	1	47	47
			34.6
REVIEW TO-MED	2	67	67
			49.3
ASK NURSE	3	14	14
			10.3
OTHER	4	8	8
			5.9
	COLUMN TOTAL	136	136
		100.0	100.0

NUMBER OF MISSING OBSERVATIONS = 262

Table 57

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

"DOCTOR'S ORDERS MEDICATION/DOCTOR'S ORDERS NONMEDICATION

(DA FORM 4256-1 TEST; DA FORM 4256-2 TEST) -

DURING THE TEST PERIOD, AFTER THE SEPARATION OF ORDERS,

IF UNFAMILIAR WITH A PATIENT, I MOST OFTEN DETERMINED

CURRENT MEDICATION(S) BY . . ."

BY TYPE OF PROVIDER

D7	COUNT	TYPE PROFESSIONAL (41)	ROW TOTAL
REVIEW ALL DR OR	1	64	64
			46.0
REVIEW TO-MED	2	56	56
			40.3
ASK NURSE	3	14	14
			10.1
OTHER	4	5	5
			3.6
	COLUMN TOTAL	139	139
		100.0	100.0

NUMBER OF MISSING OBSERVATIONS = 259

Table 58

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

"DOCTOR'S ORDERS MEDICATION/DOCTOR'S ORDERS NONMEDICATION

(DA FORM 4256-1 TEST; DA FORM 4256-2 TEST) -

IF WE WENT BACK TO THE 'OLD' ORDER SHEETS, I WOULD

HAVE NO DIFFICULTY IDENTIFYING COMPLETED SINGLE

ACTION ORDERS"

BY TYPE OF PROVIDER

	TYPE			
COUNT	IRNS	PARA	WARD CLERK	ROW TOTAL
DB	1	2	3	
1 STRONGLY AGREE	19	9	4	31
				13.7
2 AGREE	34	25	7	66
				29.1
3 DISAGREE	56	40	3	99
				43.6
4 STRONGLY DISAGRE	18	12	1	31
				13.7
COLUMN TOTAL	127	85	15	227
	55.9	37.4	6.6	100.0

NUMBER OF MISSING OBSERVATIONS = 171

Table 59

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

"DOCTOR'S ORDERS MEDICATION/DOCTOR'S ORDERS NONMEDICATION

(DA FORM 4256-1 TEST; DA FORM 4256-2 TEST) -

IF WE WENT BACK TO THE 'OLD' ORDER SHEETS, I WOULD STILL

WANT A COLUMN FOR SINGLE ACTION ORDERS TO PRECLUDE

MY HAVING TO RECOPY THEM ONTO THE THERAPEUTIC

DOCUMENTATION CARE PLANS"

BY TYPE OF PROVIDER

D9	COUNT	TYPE 1 IRNS	PARA	WARD CLERK	ROW TOTAL
		1	2	3	
STRONGLY AGREE	1	75	30	8	113
					49.3
AGREE	2	39	41	5	85
					37.1
DISAGREE	3	14	10	1	25
					10.9
STRONGLY DISAGRE	4	2	2	2	6
					2.6
	COLUMN TOTAL	130 56.8	83 36.2	16 7.0	229 100.0

NUMBER OF MISSING OBSERVATIONS = 169

Table 60

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

I LIKE BEING ABLE TO DOCUMENT (WITH EFFECTIVENESS CODES OR KEY WORDS) THE PATIENT'S RESPONSE DIRECTLY ON THE THERAPEUTIC DOCUMENTATION CARE PLANS"

BY TYPE OF PROVIDER

E1	COUNT / TYPE	IRNS 11	PARA 21	ROW TOTAL
1	STRONGLY AGREE	56	19	75
				35.0
2	AGREE	59	57	116
				54.2
3	DISAGREE	8	9	17
				7.9
4	STRONGLY DISAGRE	4	2	6
				2.8
	COLUMN TOTAL	127	87	214
		59.3	40.7	100.0

NUMBER OF MISSING OBSERVATIONS = 184

Table 61

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

"MOST OF MY DOCUMENTATION IS RECORDED ON THE THERAPEUTIC DOCUMENTATION CARE PLANS"

BY TYPE OF PROVIDER

E2	COUNT	TYPE PARA 21	ROW TOTAL
STRONGLY AGREE	1	8	8 9.5
AGREE	2	51	51 60.7
DISAGREE	3	21	21 25.0
STRONGLY DISAGREE	4	4	4 4.8
	COLUMN TOTAL	84 100.0	84 100.0

NUMBER OF MISSING OBSERVATIONS = 314

Table 62

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

"IN THE PAST, I USED TO DO MOST OF MY DOCUMENTING ON THE NURSING NOTES (SF 510)"

BY TYPE OF PROVIDER

E3	COUNT	TYPE PARA 21	ROW TOTAL
1 STRONGLY AGREE		34	34
			40.0
2 AGREE		47	47
			55.3
3 DISAGREE		3	3
			3.5
4 STRONGLY DISAGREE		1	1
			1.2
	COLUMN TOTAL	85	85
		100.0	100.0

NUMBER OF MISSING OBSERVATIONS = 313

Table 63

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

"RECORDING THE PATIENT'S RESPONSE ON THE TD CARE PLAN IMPROVES MY DOCUMENTATION OF PATIENT CARE"

BY TYPE OF PROVIDER

E4	COUNT	TYPE IRNS 11	PARA 21	ROW TOTAL
STRONGLY AGREE	1	34	19	53
				25.1
AGREE	2	72	52	124
				58.8
DISAGREE	3	18	13	31
				14.7
STRONGLY DISAGRE	4	3		3
				1.4
	COLUMN TOTAL	127	84	211
		60.2	39.8	100.0

NUMBER OF MISSING OBSERVATIONS = 187

Table 64

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

"RECORDING THE PATIENT'S RESPONSE ON THE THERAPEUTIC DOCUMENTATION CARE PLAN ENCOURAGES ME TO WRITE MORE NURSING ORDERS TO DESCRIBE NURSING ACTIVITIES WITH THE PATIENT"

BY TYPE OF PROVIDER

E5	COUNT	TYPE IRNS 11	ROW TOTAL
STRONGLY AGREE	1	25	25
			20.0
AGREE	2	62	62
			49.6
DISAGREE	3	34	34
			27.2
STRONGLY DISAGRE	4	4	4
			3.2
	COLUMN TOTAL	125	125
		100.0	100.0

NUMBER OF MISSING OBSERVATIONS = 273

Table 65

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

"RECORDING THE PATIENT'S RESPONSE ON THE THERAPEUTIC DOCUMENTATION CARE PLAN IMPROVES COMMUNICATION AMONG NURSING PERSONNEL"

BY TYPE OF PROVIDER

E6	TYPE IRNS (11)	PARA (21)	ROW TOTAL
1 STRONGLY AGREE	27	19	46 21.5
2 AGREE	75	55	130 60.7
3 DISAGREE	22	11	33 15.4
4 STRONGLY DISAGRE	4	1	5 2.3
COLUMN TOTAL	128 59.8	86 40.2	214 100.0

NUMBER OF MISSING OBSERVATIONS = 184

Table 66

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

"RECORDING THE PATIENT'S RESPONSE ON THE THERAPEUTIC DOCUMENTATION CARE PLAN IMPROVES COMMUNICATION BETWEEN NURSES AND OTHER HEALTH CARE PROVIDERS"

BY TYPE OF PROVIDER

E7	COUNT	TYPE 1 RNS 1	TYPE 2 PARA 2	ROW TOTAL
1 STRONGLY AGREE	1	18	19	37
				17.4
2 AGREE	2	66	48	114
				53.5
3 DISAGREE	3	39	17	56
				26.3
4 STRONGLY DISAGREE	4	5	1	6
				2.8
	COLUMN TOTAL	128	85	213
		60.1	39.9	100.0

NUMBER OF MISSING OBSERVATIONS = 185

Table 67

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

"RECORDING THE PATIENT'S RESPONSE ON THE TD CARE PLAN HAS DECREASED FRAGMENTED DOCUMENTATION IN THE RECORD"

BY TYPE OF PROVIDER

E8	TYPE RNS (1)	PARA (2)	ROW TOTAL
1 STRONGLY AGREE	24	17	41 19.4
2 AGREE	75	49	124 58.8
3 DISAGREE	27	15	42 19.9
4 STRONGLY DISAGRE	2	2	4 1.9
COLUMN TOTAL	128 60.7	83 39.3	211 100.0

NUMBER OF MISSING OBSERVATIONS = 187

Table 68

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

"RECORDING THE PATIENT'S RESPONSE ON THE TD CARE PLAN

ALLOWS ME TO GIVE A MORE THOROUGH REPORT"

BY TYPE OF PROVIDER

E9	COUNT / TYPE: IRNS	ROW TOTAL
1 STRONGLY AGREE	25	25
		20.0
2 AGREE	70	70
		56.0
3 DISAGREE	28	28
		22.4
4 STRONGLY DISAGRE	2	2
		1.6
COLUMN TOTAL	125	125
	100.0	100.0

NUMBER OF MISSING OBSERVATIONS = 273

Table 69

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

"RECORDING THE PATIENT'S RESPONSE ON THE TD CARE PLAN GIVES ME A BETTER 'PICTURE' OF WHAT HAPPENED TO THE PATIENT"

BY TYPE OF PROVIDER

E10	COUNT	TYPE IRNS 1	PARA 2	ROW TOTAL
STRONGLY AGREE	1	25	20	45
				20.9
AGREE	2	76	51	127
				59.1
DISAGREE	3	26	13	39
				18.1
STRONGLY DISAGREE	4	2	2	4
				1.9
	COLUMN TOTAL	129 60.0	86 40.0	215 100.0

NUMBER OF MISSING OBSERVATIONS = 183

Table 70

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

"I DID NOT DOCUMENT PATIENT RESPONSES ON THE THERAPUETIC DOCUMENTATION CARE PLANS"

BY TYPE OF PROVIDER

E11	TYPE 1 RNS	2 PARA	ROW TOTAL
1 STRONGLY AGREE	2 1.5	1 1.5	3 1.5
2 AGREE	22 16.9	25 30.9	47 23.0
3 DISAGREE	75 61.0	46 56.8	121 59.3
4 STRONGLY DISAGRE	24 19.5	9 11.1	33 16.2
COLUMN TOTAL	123 60.3	81 39.7	204 100.0

NUMBER OF MISSING OBSERVATIONS = 194

Table 71

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

"I HAD MINIMAL DIFFICULTY RECORDING THE PATIENT'S RESPONSES ON THE THERAPEUTIC DOCUMENTATION CARE PLAN"

BY TYPE OF PROVIDER

E12	COUNT	TYPE IRNS (1)	PARA (2)	ROW TOTAL
STRONGLY AGREE	1	23	9	32
				15.5
AGREE	2	69	56	125
				60.4
DISAGREE	3	29	16	45
				21.7
STRONGLY DISAGRE	4	3	2	5
				2.4
	COLUMN TOTAL	124	83	207
		59.9	40.1	100.0

NUMBER OF MISSING OBSERVATIONS = 191

Table 72

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

"THE EXPANDED USE OF THE THERAPEUTIC DOCUMENTATION CARE PLAN (BEING ABLE TO DOCUMENT RESPONSES) IS A CONCEPT WHICH SHOULD BE AVAILABLE TO ALL NURSING PERSONNEL WORLDWIDE"

BY TYPE OF PROVIDER

E13	COUNT / TYPE	IRNS (1)	PARA (2)	ROW TOTAL
1		49	25	74
STRONGLY AGREE				35.7
2		58	48	106
AGREE				51.2
3		16	8	24
DISAGREE				11.6
4		2	1	3
STRONGLY DISAGRE				1.4
	COLUMN TOTAL	125	82	207
		60.4	39.6	100.0

NUMBER OF MISSING OBSERVATIONS = 191

Table 73

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

"THE 'FOLDER' TYPE FORMAT OF THE THERAPEUTIC DOCUMENTATION CARE PLANS IS AN IMPROVEMENT"

BY TYPE OF PROVIDER

E14	COUNT	TYPE IRNS 1	PARA 2	WARD CLERK 3	ROW TOTAL
1 STRONGLY AGREE	1	48	30	8	86 37.1
2 AGREE	2	54	45	6	105 45.3
3 DISAGREE	3	20	8		28 12.1
4 STRONGLY DISAGRE	4	7	4	2	13 5.6
	COLUMN TOTAL	129 55.6	87 37.5	16 6.9	232 100.0

NUMBER OF MISSING OBSERVATIONS = 166

Table 74

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

"THE 'FOLDER' TYPE FORMAT OF THE THERAPEUTIC DOCUMENTATION CARE PLANS SHOULD BE KEPT EVEN IF IT CANNOT BE OVERPRINTED WITH ORDERS"

BY TYPE OF PROVIDER

E15	COUNT	TYPE IRNS 1	PARA 2	WARD CLERK 3	ROW TOTAL
1 STRONGLY AGREE	1	35	24	4	63 27.5
2 AGREE	2	55	45	7	107 46.7
3 DISAGREE	3	26	15	3	44 19.2
4 STRONGLY DISAGRE	4	11	3	1	15 6.6
	COLUMN TOTAL	127 55.5	87 38.0	15 6.6	229 100.0

NUMBER OF MISSING OBSERVATIONS = 169

Table 75

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

"THE 'FOLDER' TYPE FORMAT OF THE THERAPEUTIC DOCUMENTATION CARE PLANS SHOULD HAVE THE PATIENT IDENTIFICATION BLOCK PRINTED ON ALL PAGES"

BY TYPE OF PROVIDER

E16	COUNT	TYPE IRNS 1	PARA 2	WARD CLERK 3	ROW TOTAL
1 STRONGLY AGREE		32	32	3	67
					29.1
2 AGREE		47	31	2	80
					34.8
3 DISAGREE		45	20	7	72
					31.3
4 STRONGLY DISAGRE		5	4	2	11
					4.8
	COLUMN TOTAL	129	87	14	230
		56.1	37.8	6.1	100.0

NUMBER OF MISSING OBSERVATIONS = 168

Table 76

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

"I LIKE THE STURDIER PAPER ON WHICH THE FORMS ARE PRINTED"

BY TYPE OF PROVIDER

E17	COUNT	TYPE IRNS 11	PARA 21	WARD CLERK 31	ROW TOTAL
1 STRONGLY AGREE		70	38	5	113
					48.9
2 AGREE		56	44	9	109
					47.2
3 DISAGREE		3	2		5
					2.2
4 STRONGLY DISAGREE		2	1	1	4
					1.7
	COLUMN TOTAL	131	85	15	231
		56.7	36.8	6.5	100.0

NUMBER OF MISSING OBSERVATIONS = 167

Table 77

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

"HAVING SEPARATE PAGES FOR RECURRING, DELAYED, OR PRN ACTION ORDERS IS HELPFUL TO ME"

BY TYPE OF PROVIDER

E18	TYPE COUNT IRNS 1	PARA 2	WARD CLERK 3	ROW TOTAL
1 STRONGLY AGREE	56 56.0 44.8	30 30.0 36.1	4 4.0 26.7	90 40.4
2 AGREE	56 50.0 44.8	46 41.1 55.4	10 8.9 66.7	112 50.2
3 DISAGREE	10 71.4 8.0	4 28.6 4.8	0 0.0 0.0	14 6.3
4 STRONGLY DISAGREE	3 42.9 2.4	3 42.9 3.6	1 14.3 6.7	7 3.1
COLUMN TOTAL	125 56.1	83 37.2	15 6.7	223 100.0

NUMBER OF MISSING OBSERVATIONS = 175

Table 78

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

"TO MY KNOWLEDGE, THERE WERE NO TREATMENT OR MEDICATION ERRORS COMMITTED ON MY NURSING UNIT WHICH COULD BE BLAMED ON THE NEW FORMAT OF THE THERAPEUTIC DOCUMENTATION CARE PLANS"

BY TYPE OF PROVIDER

E19	COUNT	TYPE IRNS (1)	PARA (2)	ROW TOTAL
1 STRONGLY AGREE	1	33	25	58
				28.0
2 AGREE	2	50	38	88
				42.5
3 DISAGREE	3	30	16	46
				22.2
4 STRONGLY DISAGREE	4	12	3	15
				7.2
	COLUMN TOTAL	125	82	207
		60.4	39.6	100.0

NUMBER OF MISSING OBSERVATIONS = 191

Table 79

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

"I WOULD PREFER TO HAVE THE THERAPEUTIC DOCUMENTATION CARE PLANS IN A SINGLE SHEET FORMAT (LIKE THE 'OLD' TDs) EVEN KNOWING THAT I WOULD HAVE LESS ROOM FOR DOCUMENTATION"

BY TYPE OF PROVIDER

E20	COUNT / TYPE	IRNS (1)	PARA (2)	WARD CLERK (3)	ROW TOTAL
1		11	4		15
STRONGLY AGREE					6.7
2		21	14	2	37
AGREE					16.6
3		63	48	10	121
DISAGREE					54.3
4		31	17	2	50
STRONGLY DISAGREE					22.4
	COLUMN TOTAL	126	83	14	223
		56.5	37.2	6.3	100.0

NUMBER OF MISSING OBSERVATIONS = 175

Table 80

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

"IF A SINGLE SHEET FORMAT WERE TO BE USED, I WOULD PREFER A MEDIUM WEIGHT PAPER (LESS BULKY THAN THE TESTED PAPER)"

BY TYPE OF PROVIDER

E21	COUNT / TYPE	IRNS 1	PARA 2	WARD CLERK 3	ROW TOTAL
1	STRONGLY AGREE	5	5		10
					4.5
2	AGREE	26	21	4	51
					22.9
3	DISAGREE	74	47	10	131
					58.7
4	STRONGLY DISAGRE	21	10		31
					13.9
	COLUMN TOTAL	126	83	14	223
		56.5	37.2	6.3	100.0

NUMBER OF MISSING OBSERVATIONS = 175

Table 81

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

"ALL MEDICATION AND NONMEDICATION FORMS SHOULD REMAIN COLOR CODED"

BY TYPE OF PROVIDER

E22	TYPE IRNS 1	PARA 2	WARD CLERK 3	ROW TOTAL
1 STRONGLY AGREE	85	41	9	135
				58.7
2 AGREE	41	42	7	90
				39.1
3 DISAGREE	3	1		4
				1.7
4 STRONGLY DISAGRE	1			1
				.4
COLUMN TOTAL	130	84	16	230
	56.5	36.5	7.0	100.0

NUMBER OF MISSING OBSERVATIONS = 168

Table 82

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

"YELLOW HIGHLIGHTER USE SHOULD BE REINSTATED TO DISCONTINUE ORDERS"

BY TYPE OF PROVIDER

E23	COUNT	TYPE RNS 1	PARA 2	WARD CLERK 3	ROW TOTAL
1 STRONGLY AGREE		64	42	6	112 48.9
2 AGREE		32	27	5	64 27.9
3 DISAGREE		23	11	2	36 15.7
4 STRONGLY DISAGRE		11	4	2	17 7.4
	COLUMN TOTAL	130 56.8	84 36.7	15 6.6	229 100.0

NUMBER OF MISSING OBSERVATIONS = 169

Table 83

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

"THE INTEGRATED PROGRESS NOTE IMPROVES COMMUNICATIONS CONCERNING THE PATIENT AMONG ALL HEALTH CARE PROVIDERS"

BY TYPE OF PROVIDER

F1	TYPE			
COUNT	IRNS (1)	PARA (2)	PROFESSIONAL (4)	ROW TOTAL
1 STRONGLY AGREE	61	34	46	141
				38.8
2 AGREE	57	44	62	163
				44.9
3 DISAGREE	10	6	25	41
				11.3
4 STRONGLY DISAGREE	3		15	18
				5.0
COLUMN TOTAL	131	84	148	363
	36.1	23.1	40.8	100.0

NUMBER OF MISSING OBSERVATIONS = 35

Table 84

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

"THE INTEGRATED PROGRESS NOTE HAS ENCOURAGED ME TO BE MORE THOROUGH IN DOCUMENTATION"

BY TYPE OF PROVIDER

F2	COUNT	TYPE IRNS 11	PARA 21	ROW TOTAL
1 STRONGLY AGREE	1	43	22	65
				30.5
2 AGREE	2	47	46	93
				43.7
3 DISAGREE	3	33	17	50
				23.5
4 STRONGLY DISAGRE	4	5		5
				2.3
	COLUMN TOTAL	128 60.1	85 39.9	213 100.0

NUMBER OF MISSING OBSERVATIONS = 185

Table 85

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

"THE INTEGRATED PROGRESS NOTE HAS ENCOURAGED ME TO BE MORE CONCISE IN DOCUMENTATION"

BY TYPE OF PROVIDER

F3	COUNT	TYPE IRNS 1	PARA 2	ROW TOTAL
1 STRONGLY AGREE	1	44	20	64
				30.0
AGREE	2	70	56	126
				59.2
DISAGREE	3	11	9	20
				9.4
4 STRONGLY DISAGRE	4	3		3
				1.4
	COLUMN TOTAL	128	85	213
		60.1	39.9	100.0

NUMBER OF MISSING OBSERVATIONS = 185

Table 86

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

"THE INTEGRATED PROGRESS NOTE LESSENS FRAGMENTING OF INFORMATION IN THE PATIENT RECORD"

BY TYPE OF PROVIDER

F4	COUNT / TYPE	IRNS 1	PARA 2	PROFESSIONAL 4	ROW TOTAL
1	STRONGLY AGREE	52	21	42	115
					31.8
2	AGREE	66	53	58	177
					48.9
3	DISAGREE	11	9	32	52
					14.4
4	STRONGLY DISAGRE	2	1	15	18
					5.0
	COLUMN TOTAL	131	84	147	362
		36.2	23.2	40.6	100.0

NUMBER OF MISSING OBSERVATIONS = 36

Table 87

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

"THE INTEGRATED PROGRESS NOTE LESSENS THE AMOUNT OF INFORMATION EVERYONE MUST DOCUMENT"

BY TYPE OF PROVIDER

F5	TYPE 1 RNS	11 PARA	21 PROFESSIONAL	41	ROW TOTAL
1 STRONGLY AGREE	49	24	19		92 25.4
2 AGREE	59	41	39		139 38.4
3 DISAGREE	17	17	68		102 28.2
4 STRONGLY DISAGRE	5	2	22		29 8.0
COLUMN TOTAL	130 35.9	84 23.2	148 40.9		362 100.0

NUMBER OF MISSING OBSERVATIONS = 36

Table 88

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

"THE INTEGRATED PROGRESS NOTE ENCOURAGES ME TO READ NARRATIVE NURSING NOTES MORE THAN I DID IN THE PAST"

BY TYPE OF PROVIDER

	TYPE	
COUNT	PROFES-SIONAL	ROW TOTAL
FE 4		
1 STRONGLY AGREE	30	30
		20.3
2 AGREE	67	67
		45.3
3 DISAGREE	32	32
		21.6
4 STRONGLY DISAGRE	19	19
		12.8
COLUMN TOTAL	148	148
	100.0	100.0

NUMBER OF MISSING OBSERVATIONS = 250

Table 89

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

"THE INTEGRATED PROGRESS NOTE MAKES IT EASIER TO DETERMINE WHAT IS HAPPENING WITH MY PATIENT"

BY TYPE OF PROVIDER

F7	COUNT	TYPE PROFESSIONAL (41)	ROW TOTAL
STRONGLY AGREE	1	27	27
			18.0
AGREE	2	70	70
			46.7
DISAGREE	3	32	32
			21.3
STRONGLY DISAGRE	4	21	21
			14.0
	COLUMN TOTAL	150	150
		100.0	100.0

NUMBER OF MISSING OBSERVATIONS = 248

Table 90

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

"THE INTEGRATED PROGRESS NOTE HAS SAVED ME TIME IN DOCUMENTING

(I FEEL I DON'T NEED TO REPEAT INFORMATION PREVIOUSLY

DOCUMENTED BY ANOTHER HEALTH CARE PROVIDER BECAUSE

IT'S ALL IN THE SAME PLACE)"

BY TYPE OF PROVIDER

FB	COUNT	TYPE IRNS 1	PARA 2	ROW TOTAL
STRONGLY AGREE	1	66	32	98
				46.7
AGREE	2	50	37	87
				41.4
DISAGREE	3	8	11	19
				9.0
STRONGLY DISAGRE	4	4	2	6
				2.9
	COLUMN TOTAL	128	82	210
		61.0	39.0	100.0

NUMBER OF MISSING OBSERVATIONS = 188

Table 91

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

"THE INTEGRATED PROGRESS NOTE ENCOURAGES ME TO READ OTHER CARE PROVIDERS' NOTES"

BY TYPE OF PROVIDER

F9	COUNT	TYPE IRNS 1	PARA 2	ROW TOTAL
1 STRONGLY AGREE	1	68 50.7	27 31.8	95 43.4
2 AGREE	2	58 43.3	49 57.6	107 48.9
3 DISAGREE	3	6 4.5	8 9.4	14 6.4
4 STRONGLY DISAGREE	4	2 1.5	1 1.2	3 1.4
	COLUMN TOTAL	134 61.2	85 38.8	219 100.0

NUMBER OF MISSING OBSERVATIONS = 179

Table 92

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

"THE INTEGRATED PROGRESS NOTE SHOULD BE USED AT ALL ARMY HOSPITALS"

BY TYPE OF PROVIDER

F10	TYPE COUNT	RNS 1	PARA 2	PROFESSIONAL 4	ROW TOTAL
1 STRONGLY AGREE		79	32	37	148 41.5
2 AGREE		43	45	55	143 40.1
3 DISAGREE		7	5	25	37 10.4
4 STRONGLY DISAGREE		1	1	27	29 8.1
	COLUMN TOTAL	130 36.4	83 23.2	144 40.3	357 100.0

NUMBER OF MISSING OBSERVATIONS = 41

Table 93

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

"I HAD LITTLE DIFFICULTY IDENTIFYING WHO WROTE PREVIOUS NARRATIVE NOTATIONS"

BY TYPE OF PROVIDER

F11	COUNT	TYPE PROFESSIONAL 4	ROW TOTAL
STRONGLY AGREE	1	19	19 13.0
AGREE	2	85	85 58.2
DISAGREE	3	32	32 21.9
STRONGLY DISAGREE	4	10	10 6.8
	COLUMN TOTAL	146 100.0	146 100.0

NUMBER OF MISSING OBSERVATIONS = 252

Table 94

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

"I HAD NO DIFFICULTY DISTINGUISHING NURSING NOTATIONS FROM THOSE OF OTHER DISCIPLINES"

BY TYPE OF PROVIDER

F12	TYPE IRNS 1	PARA 2	PROFESSIONAL 4	ROW TOTAL
1 STRONELY AGREE	56	21	28	105 29.1
2 AGREE	64	53	91	208 57.6
3 DISAGREE	9	9	21	39 10.8
4 STRONELY DISAGRE	3	2	4	9 2.5
COLUMN TOTAL	132 36.6	85 23.5	144 39.9	361 100.0

NUMBER OF MISSING OBSERVATIONS = 37

Table 95

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

"I HAD LITTLE DIFFICULTY LOCATING MY PREVIOUS NARRATIVE NOTATIONS"

BY TYPE OF PROVIDER

		TYPE	
	COUNT	I PROFESSIONAL	ROW TOTAL
		I 4 I	
F12	1	36	36
STRONGLY AGREE			25.0
	2	82	82
AGREE			56.9
	3	18	18
DISAGREE			12.5
	4	8	8
STRONGLY DISAGRE			5.6
	COLUMN TOTAL	144 100.0	144 100.0

NUMBER OF MISSING OBSERVATIONS: 254

Table 96

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

"PHYSICIANS ON MY NURSING UNIT SEEMED TO LIKE HAVING NARRATIVE NURSING COMMENTS INTEGRATED WITH OTHER PATIENT CARE DOCUMENTATION"

BY TYPE OF PROVIDER

F14	TYPE IRNS (1)	PARA (2)	ROW TOTAL
1 STRONGLY AGREE	21	12	33 16.8
2 AGREE	70	44	114 58.2
3 DISAGREE	26	16	42 21.4
4 STRONGLY DISAGRE	4	3	7 3.6
COLUMN TOTAL	121 61.7	75 38.3	196 100.0

NUMBER OF MISSING OBSERVATIONS = 201

Table 97

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

"OTHER HEALTH CARE PROVIDERS (e.g., PHYSICAL THERAPIST, DIETITIAN, SOCIAL WORKER) SEEMED TO LIKE HAVING NARRATIVE NURSING COMMENTS INTEGRATED WITH OTHER PATIENT CARE DOCUMENTATION"

BY TYPE OF PROVIDER

F15	TYPE IRNS (1)	TYPE PARA (2)	ROW TOTAL
1 STRONGLY AGREE	16	18	34
			17.7
2 AGREE	88	51	139
			72.4
3 DISAGREE	11	5	16
			8.3
4 STRONGLY DISAGRE	1	2	3
			1.6
COLUMN TOTAL	116	76	192
	60.4	39.6	100.0

NUMBER OF MISSING OBSERVATIONS: 204

Table 9

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

"ALTHOUGH THE GUIDELINES READ THAT ALL NURSING PERSONNEL WERE AUTHORIZED TO CHART ON THE PROGRESS NOTES, THERE WERE SOME EXCEPTIONS TO THIS POLICY ON MY NURSING UNIT"

BY TYPE OF PROVIDER

F13	COUNT	TYPE IRNS 1	PARA 2	ROW TOTAL
STRONGLY AGREE	1	5	1	6
				2.9
AGREE	2	22	21	43
				21.1
DISAGREE	3	66	43	109
				53.4
STRONGLY DISAGREE	4	32	14	46
				22.5
	COLUMN TOTAL	125	79	204
		61.3	38.7	100.0

NUMBER OF MISSING OBSERVATIONS: 194

Table 99

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

"IN MY OPINION, THE BOTTOM LINE TO EVERYTHING WE HAVE TESTED IS. . ."

BY TYPE OF PROVIDER

C1	TYPE			
COUNT / ROW PCT / COL PCT	IRNS 1	PARA 2	WARD CLERK 3	ROW TOTAL
1 IMPLEMENT EXACTL	111	138	14	263
	42.2	52.5	5.3	53.1
	42.5	67.0	50.0	
2 GO BACK TO OLD	3	6	3	12
	25.0	50.0	25.0	2.4
	1.1	2.9	10.7	
3 IMPLEMENT W MODI	147	62	11	220
	66.8	28.2	5.0	44.4
	56.3	30.1	39.3	
COLUMN TOTAL	261	206	28	495
	52.7	41.6	5.7	100.0

NUMBER OF MISSING OBSERVATIONS= 351

Table 100

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

GENERAL COMMENTS REGARDING THE TEST FORMS

BY TYPE OF PROVIDER

COMMENTS	TYPE				ROW TOTAL
	IRN	PARA	WARD CLERK	PROFES-SIONAL	
	1	2	3	4	
1	8	7	1	2	18
DR ORDER +GEN SAT	44.4	38.9	5.6	11.1	25.7
	47.1	28.0	7.1	14.3	
	11.4	10.0	1.4	2.9	
4	1	0	0	0	1
DR ORD-GEN-PAPERWRK	100.0	0.0	0.0	0.0	1.4
	5.9	0.0	0.0	0.0	
	1.4	0.0	0.0	0.0	
8	0	0	2	0	2
DR ORD-MISC PROBLEM	0.0	0.0	100.0	0.0	2.9
	0.0	0.0	14.3	0.0	
	0.0	0.0	2.9	0.0	
9	0	3	1	0	4
DR ORD 1-SHEET PREFR	0.0	75.0	25.0	0.0	5.7
	0.0	12.0	7.1	0.0	
	0.0	4.3	1.4	0.0	
10	0	1	0	0	1
DR ORD REDISN COMMNT	0.0	100.0	0.0	0.0	1.4
	0.0	4.0	0.0	0.0	
	0.0	1.4	0.0	0.0	
11	7	3	3	4	17
509+ GEN SATISFACT	41.2	17.6	17.6	23.5	24.3
	41.2	12.0	21.4	28.6	
	10.0	4.3	4.3	5.7	
12	0	2	1	0	3
509+IMPROVES COMMUN	0.0	66.7	33.3	0.0	4.3
	0.0	8.0	7.1	0.0	
	0.0	2.9	1.4	0.0	
COLUMN TOTAL	17	25	14	14	70
	24.3	35.7	20.0	20.0	100.0

Table 100

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

GENERAL COMMENTS REGARDING THE TEST FORMS

BY TYPE OF PROVIDER (CONTINUED)

COMMENTS	COUNT / ROW PCT / COL PCT / TAB PCT	TYPE IRN (1)	PARA (2)	WARD CLERK (3)	PROFESSIONAL (4)	ROW TOTAL
509+ KEEP	13	0	2	1	0	3
		0.0	66.7	33.3	0.0	4.3
		0.0	8.0	7.1	0.0	
		0.0	2.9	1.4	0.0	
509- GEN PROBLEMS	14	0	0	1	0	1
		0.0	0.0	100.0	0.0	1.4
		0.0	0.0	7.1	0.0	
		0.0	0.0	1.4	0.0	
509-DECR DOCU,LEGAL	16	0	2	1	2	5
		0.0	40.0	20.0	40.0	7.1
		0.0	8.0	7.1	14.3	
		0.0	2.9	1.4	2.9	
509-NOTES QUALITY	20	1	0	1	0	2
		50.0	0.0	50.0	0.0	2.9
		5.9	0.0	7.1	0.0	
		1.4	0.0	1.4	0.0	
509 GC BACK TO SEP N	22	0	1	1	1	3
		0.0	33.3	33.3	33.3	4.3
		0.0	4.0	7.1	7.1	
		0.0	1.4	1.4	1.4	
3888-2 +GEN COMMENT	24	6	5	1	0	12
		50.0	41.7	8.3	0.0	17.1
		35.3	20.0	7.1	0.0	
		8.6	7.1	1.4	0.0	
3888-2-OLD BETTER	25	2	0	2	1	5
		40.0	0.0	40.0	20.0	7.1
		.8	0.0	14.3	7.1	
		2.9	0.0	2.9	1.4	
COLUMN TOTAL		17	25	14	14	70
		24.3	35.7	20.0	20.0	100.0

Table 100

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

GENERAL COMMENTS REGARDING THE TEST FORMS

BY TYPE OF PROVIDER (CONTINUED)

COMMENTS	TYPE 1 RN	2 PARA	3 WARD CLERK	4 PROFESSIONAL	ROW TOTAL
3888-2 REDESIGN CMTS	3	4	1	0	8
	37.5	50.0	12.5	0.0	11.4
	17.6	16.0	7.1	0.0	
	4.3	5.7	1.4	0.0	
3888-2 SPECIFIC PROB	1	1	0	0	2
	50.0	50.0	0.0	0.0	2.9
	5.9	4.0	0.0	0.0	
	1.4	1.4	0.0	0.0	
3888-3 + COMMENTS	8	6	0	1	15
	53.3	40.0	0.0	6.7	21.4
	47.1	24.0	0.0	7.1	
	11.4	8.6	0.0	1.4	
3888-3-NEVER USE	0	0	1	1	2
	0.0	0.0	50.0	50.0	2.9
	0.0	0.0	7.1	7.1	
	0.0	0.0	1.4	1.4	
3888-4+ COMMENTS	8	5	0	1	14
	57.1	35.7	0.0	7.1	20.0
	47.1	20.0	0.0	7.1	
	11.4	7.1	0.0	1.4	
3888-4-OLD BETTER	0	0	1	0	1
	0.0	0.0	100.0	0.0	1.4
	0.0	0.0	7.1	0.0	
	0.0	0.0	1.4	0.0	
3888-4 REDESIGN CMTS	0	0	0	1	1
	0.0	0.0	0.0	100.0	1.4
	0.0	0.0	0.0	7.1	
	0.0	0.0	0.0	1.4	
COLUMN TOTAL	17	25	14	14	70
	24.3	35.7	20.0	20.0	100.0

Table 100

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

GENERAL COMMENTS REGARDING THE TEST FORMS

BY TYPE OF PROVIDER (CONTINUED)

COMMENTS	COUNT / ROW PCT / COL PCT / TAB PCT	TYPE IRN (1)	PARA (2)	WARD CLERK (3)	PROFESSIONAL (4)	ROW TOTAL
3888-4 MISC COMMENTS	34	0	1	0	0	1
		0.0	100.0	0.0	0.0	1.4
		0.0	4.0	0.0	0.0	
		0.0	1.4	0.0	0.0	
3888-5+ KEEP	35	6	6	1	1	14
		42.9	42.9	7.1	7.1	20.0
		35.3	24.0	7.1	7.1	
		8.6	8.6	1.4	1.4	
3888-5+REDESIGN CMT	36	0	0	2	2	4
		0.0	0.0	50.0	50.0	5.7
		0.0	0.0	14.3	14.3	
		0.0	0.0	2.9	2.9	
3888-5 MIS COMMENTS	39	1	1	0	0	2
		50.0	50.0	0.0	0.0	2.9
		5.9	4.0	0.0	0.0	
		1.4	1.4	0.0	0.0	
TDS+KEEP,NO CHANGES	40	8	6	3	1	18
		44.4	33.3	16.7	5.6	25.7
		47.1	24.0	21.4	7.1	
		11.4	8.6	4.3	1.4	
TDS REDESIGN COMMNTS	41	4	6	2	3	15
		26.7	40.0	13.3	20.0	21.4
		23.5	24.0	14.3	21.4	
		5.7	8.6	2.9	4.3	
TDS CODING ISSUES	42	0	0	2	0	2
		0.0	0.0	100.0	0.0	2.9
		0.0	0.0	14.3	0.0	
		0.0	0.0	2.9	0.0	
	COLUMN TOTAL	17	25	14	14	70
		24.3	35.7	20.0	20.0	100.0

Table 100

[illegible] ARMY ME[illegible]

CLINICAL NURSING RECORDS STUDY

GENERAL COMMENTS REGARDING THE TEST FORMS

BY TYPE OF PROVIDER (CONTINUED)

	TYPE				
COMMENTS / COUNT / ROW PCT / COL PCT / TAB PCT	IRN 1	PARA 2	WARD CLERK 3	PROFESSIONAL 4	ROW TOTAL
TDS-OLD BETTER	0	0	1	1	2
	0.0	0.0	50.0	50.0	2.9
	0.0	0.0	7.1	7.1	
	0.0	0.0	1.4	1.4	
TDS OVERPRINT COMMEN	2	0	1	0	3
	66.7	0.0	33.3	0.0	4.3
	11.8	0.0	7.1	0.0	
	2.9	0.0	1.4	0.0	
GEN+SYS CHG CMTS	4	6	5	2	17
	23.5	35.3	29.4	11.8	24.3
	23.5	24.0	35.7	14.3	
	5.7	8.6	7.1	2.9	
GEN -CMTS,OLD BETTR	0	0	1	1	2
	0.0	0.0	50.0	50.0	2.9
	0.0	0.0	7.1	7.1	
	0.0	0.0	1.4	1.4	
REDESIGN COMMENTS	0	0	0	1	1
	0.0	0.0	0.0	100.0	1.4
	0.0	0.0	0.0	7.1	
	0.0	0.0	0.0	1.4	
SPECIFIC AREA PROBS	1	0	0	0	1
	100.0	0.0	0.0	0.0	1.4
	5.9	0.0	0.0	0.0	
	1.4	0.0	0.0	0.0	
TDS WANT YELLOW HL	1	8	0	2	11
	9.1	72.7	0.0	18.2	15.7
	5.9	32.0	0.0	14.3	
	1.4	11.4	0.0	2.9	
COLUMN TOTAL	17	25	14	14	70
	24.3	35.7	20.0	20.0	100.0

PERCENTS AND TOTALS BASED ON RESPONDENTS

70 VALID CASES [illegible] MISSING CASES

Table 101

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

GENERAL COMMENTS REGARDING DA FORM 3888-2 TEST NURSING HISTORY AND ASSESSMENT

BY TYPE OF PROVIDER

COMMENTS	COUNT / ROW PCT / COL PCT / TAB PCT	TYPE IRN (1)	PARA (2)	WARD CLERK (3)	PROFESSIONAL (4)	ROW TOTAL
24		6	5	1	0	12
3888-2 +GEN COMMENT		50.0	41.7	8.3	.0	44.4
		50.0	50.0	25.0	.0	
		22.2	18.5	3.7	.0	
25		2	0	2	1	5
3888-2-OLD BETTER		40.0	.0	40.0	20.0	18.5
		16.7	.0	50.0	100.0	
		7.4	.0	7.4	3.7	
26		3	4	1	0	8
3888-2 REDESIGN CMTS		37.5	50.0	12.5	.0	29.6
		25.0	40.0	25.0	.0	
		11.1	14.8	3.7	.0	
28		1	1	0	0	2
3888-2 SPECIFIC PROB		50.0	50.0	.0	.0	7.4
		8.3	10.0	.0	.0	
		3.7	3.7	.0	.0	
COLUMN TOTAL		12	10	4	1	27
		44.4	37.0	14.8	3.7	100.0

PERCENTS AND TOTALS BASED ON RESPONDENTS

27 VALID CASES; 239 MISSING CASES

Table 102

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

GENERAL COMMENTS REGARDING DA FORM 3888-3 TEST

NURSING HISTORY AND ASSESSMENT CONTINUATION

BY TYPE OF PROVIDER

COMMENTS	TYPE: IRN (1)	PARA (2)	WARD CLERK (3)	PROFESSIONAL (4)	ROW TOTAL
3888-3 + COMMENTS	8	6	0	1	15
	53.3	40.0	.0	6.7	88.2
	100.0	100.0	.0	50.0	
	47.1	35.3	.0	5.9	
3888-3-NEVER USE	0	0	1	1	2
	.0	.0	50.0	50.0	11.8
	.0	.0	100.0	50.0	
	.0	.0	5.9	5.9	
COLUMN TOTAL	8	6	1	2	17
	47.1	35.3	5.9	11.8	100.0

PERCENTS AND TOTALS BASED ON RESPONDENTS

17 VALID CASES; 249 MISSING CASES

Table 103

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

GENERAL COMMENTS REGARDING DA FORM 3888-4 TEST

NURSING CARE PLAN

BY TYPE OF PROVIDER

COMMENTS	COUNT / ROW PCT / COL PCT / TAB PCT	TYPE IRN (1)	PARA (2)	WARD CLERK (3)	PROFESSIONAL (4)	ROW TOTAL
3888-4+ COMMENTS	31	8	5	0	1	14
	ROW PCT	57.1	35.7	.0	7.1	82.4
	COL PCT	100.0	83.3	.0	50.0	
	TAB PCT	47.1	29.4	.0	5.9	
3888-4-OLD BETTER	32	0	0	1	0	1
	ROW PCT	.0	.0	100.0	.0	5.9
	COL PCT	.0	.0	100.0	.0	
	TAB PCT	.0	.0	5.9	.0	
3888-4 REDESIGN CMTS	33	0	0	0	1	1
	ROW PCT	.0	.0	.0	100.0	5.9
	COL PCT	.0	.0	.0	50.0	
	TAB PCT	.0	.0	.0	5.9	
3888-4 MISC COMMENTS	34	0	1	0	0	1
	ROW PCT	.0	100.0	.0	.0	5.9
	COL PCT	.0	16.7	.0	.0	
	TAB PCT	.0	5.9	.0	.0	
	COLUMN TOTAL	8	6	1	2	17
		47.1	35.3	5.9	11.8	100.0

PERCENTS AND TOTALS BASED ON RESPONDENTS

17 VALID CASES; 249 MISSING CASES

Table 104

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

GENERAL COMMENTS REGARDING DA FORM 3888-5 TEST

NURSING DISCHARGE SUMMARY

BY TYPE OF PROVIDER

		TYPE				
COMMENTS	COUNT / ROW PCT / COL PCT / TAB PCT	IRN 1	PARA 2	WARD CLERK 3	PROFES-SIONAL 4	ROW TOTAL
3888-5+ KEEP	35	6	6	1	1	14
		42.9	42.9	7.1	7.1	73.7
		85.7	85.7	33.3	50.0	
		31.6	31.6	5.3	5.3	
3888-5+REDESIGN CMT	36	0	0	2	2	4
		.0	.0	50.0	50.0	21.1
		.0	.0	66.7	100.0	
		.0	.0	10.5	10.5	
3888-5 MIS COMMENTS	39	1	1	0	0	2
		50.0	50.0	.0	.0	10.5
		14.3	14.3	.0	.0	
		5.3	5.3	.0	.0	
	COLUMN TOTAL	7	7	3	2	19
		36.8	36.8	15.8	10.5	100.0

PERCENTS AND TOTALS BASED ON RESPONDENTS

19 VALID CASES; 247 MISSING CASES

Table 105

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

GENERAL COMMENTS REGARDING DA FORM 4256-1 TEST DOCTOR'S ORDER SHEET MEDICATION

AND DA FORM 4256-2 TEST DOCTOR'S ORDER SHEET NONMEDICATION

BY TYPE OF PROVIDER

COMMENTS	COUNT / ROW PCT / COL PCT / TAB PCT	TYPE IRN 1	PARA 2	WARD CLERK 3	PROFESSIONAL 4	ROW TOTAL
1		8	7	1	2	18
DR ORDER +GEN SAT		44.4	38.9	5.6	11.1	81.8
		100.0	77.8	33.3	100.0	
		36.4	31.8	4.5	9.1	
4		1	0	0	0	1
DR ORD-GEN-PAPERWRK		100.0	.0	.0	.0	4.5
		12.5	.0	.0	.0	
		4.5	.0	.0	.0	
8		0	0	2	0	2
DR ORD-MISC PROBLEM		.0	.0	100.0	.0	9.1
		.0	.0	66.7	.0	
		.0	.0	9.1	.0	
9		0	3	1	0	4
DR ORD 1-SHEET PREFR		.0	75.0	25.0	.0	18.2
		.0	33.3	33.3	.0	
		.0	13.6	4.5	.0	
10		0	1	0	0	1
DR ORD REDISN COMMNT		.0	100.0	.0	.0	4.5
		.0	11.1	.0	.0	
		.0	4.5	.0	.0	
COLUMN TOTAL		8	9	3	2	22
		36.4	40.9	13.6	9.1	100.0

PERCENTS AND TOTALS BASED ON RESPONDENTS

22 VALID CASES; 244 MISSING CASES

Table 106

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

GENERAL COMMENTS REGARDING

DA FORM 4677-1 TEST THERAPEUTIC DOCUMENTATION CARE PLAN NONMEDICATION

AND DA FORM 4678-1 TEST THERAPEUTIC DOCUMENTATION CARE PLAN MEDICATION

BY TYPE OF PROVIDER

	TYPE				
COMMENTS	COUNT / ROW PCT / COL PCT / TAB PCT	IRN 1	PARA 2	WARD CLERK 3	PROFESSIONAL 4	ROW TOTAL
TDS+KEEP,NO CHANGES	40	8	6	3	1	18
		44.4	33.3	16.7	5.6	48.6
		57.1	50.0	50.0	20.0	
		21.6	16.2	8.1	2.7	
TDS REDESIGN COMMNTS	41	4	6	2	3	15
		26.7	40.0	13.3	20.0	40.5
		28.6	50.0	33.3	60.0	
		10.8	16.2	5.4	8.1	
TDS CODING ISSUES	42	0	0	2	0	2
		.0	.0	100.0	.0	5.4
		.0	.0	33.3	.0	
		.0	.0	5.4	.0	
TDS-OLD BETTER	43	0	0	1	1	2
		.0	.0	50.0	50.0	5.4
		.0	.0	16.7	20.0	
		.0	.0	2.7	2.7	
TDS OVERPRINT COMMEN	44	2	0	1	0	3
		66.7	.0	33.3	.0	8.1
		14.3	.0	16.7	.0	
		5.4	.0	2.7	.0	
	COLUMN TOTAL	14	12	6	5	37
		37.8	32.4	16.2	13.5	100.0

PERCENTS AND TOTALS BASED ON RESPONDENTS

37 VALID CASES; 229 MISSING CASES

Table 107

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

GENERAL COMMENTS REGARDING INTEGRATED PROGRESS NOTES

BY TYPE OF PROVIDER

COMMENTS	COUNT / ROW PCT / COL PCT / TAB PCT	IRN 1	PARA 2	WARD CLERK 3	PROFES-SIONAL 4	ROW TOTAL
11		7	3	3	4	17
509+ GEN SATISFACT		41.2	17.6	17.6	23.5	54.8
		87.5	33.3	42.9	57.1	
		22.6	9.7	9.7	12.9	
12		0	2	1	0	3
509+IMPROVES COMMUN		.0	66.7	33.3	.0	9.7
		.0	22.2	14.3	.0	
		.0	6.5	3.2	.0	
13		0	2	1	0	3
509+ KEEP		.0	66.7	33.3	.0	9.7
		.0	22.2	14.3	.0	
		.0	6.5	3.2	.0	
14		0	0	1	0	1
509- GEN PROBLEMS		.0	.0	100.0	.0	3.2
		.0	.0	14.3	.0	
		.0	.0	3.2	.0	
16		0	2	1	2	5
509-DECR DOCU,LEGAL		.0	40.0	20.0	40.0	16.1
		.0	22.2	14.3	28.6	
		.0	6.5	3.2	6.5	
20		1	0	1	0	2
509-NOTES QUALITY		50.0	.0	50.0	.0	6.5
		12.5	.0	14.3	.0	
		3.2	.0	3.2	.0	
22		0	1	1	1	3
509 GO BACK TO SEP N		.0	33.3	33.3	33.3	9.7
		.0	11.1	14.3	14.3	
		.0	3.2	3.2	3.2	
COLUMN TOTAL		8	9	7	7	31
		25.8	29.0	22.6	22.6	100.0

PERCENTS AND TOTALS BASED ON RESPONDENTS

31 VALID CASES; 235 MISSING CASES

Table 108

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

CURRENT DUTY ASSIGNMENT

BY TYPE OF PROVIDER

H1	TYPE IRNS 11	PARA 21	ROW TOTAL
1 CLIN STAFF NURSE	94		94 43.5
2 CLIN HEAD NURSE	21		21 9.7
3 CLIN NURSE SPEC	8		8 3.7
4 SPEC PRACTICES	8		8 3.7
7 OTHER	1		1 .5
8 91A-AIDE		2	2 .9
10 91C PRACT NRS		73	73 33.8
11 91F-PSYCH TECH		8	8 3.7
12 OTHER		1	1 .5
COLUMN TOTAL	132 61.1	84 38.9	216 100.0

NUMBER OF MISSING OBSERVATIONS = 182

Table 109

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

"ARE YOU A WARDMASTER?"

BY TYPE OF PROVIDER

H2	COUNT	TYPE PARA 2	ROW TOTAL
YES	1	17	17 20.7
NO	2	65	65 79.3
	COLUMN TOTAL	82 100.0	82 100.0

NUMBER OF MISSING OBSERVATIONS = 316

Table 110

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

PRIMARY INPATIENT NURSING UNIT

BY TYPE OF PROVIDER

H3	COUNT / TYPE	IRNS 1	PARA 2	WARD CLERK 3	ROW TOTAL
1		43	22	6	71
SURG UNIT					30.2
2		3	10	1	14
PSYCH UNIT					6.0
3		15	14	3	32
MED UNIT					13.6
4		2	6		8
COMBINED MED SUR					3.4
5		7	5	1	13
PEDS UNIT					5.5
6		34	20	2	56
ALL ICU S					23.8
7		13	5	2	20
L&D NBN POST PAR					8.5
8		17			17
OR ANES					7.2
9		3	1		4
OTHER					1.7
	COLUMN TOTAL	137	83	15	235
		58.3	35.3	6.4	100.0

NUMBER OF MISSING OBSERVATIONS = 163

Table 111

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

NUMBER OF YEARS WORKED AS A REGISTERED NURSE

BY TYPE OF PROVIDER

H4	COUNT / TYPE: IRNS (11)	ROW TOTAL
1	14	14 11.9
2	20	20 16.9
3	3	3 2.5
4	4	4 3.4
5	7	7 5.9
6	10	10 8.5
7	5	5 4.2
8	9	9 7.6
9	3	3 2.5
10	4	4 3.4
11	4	4 3.4
12	4	4 3.4
13	8	8 6.8
14	3	3 2.5
15	6	6 5.1
16	3	3 2.5
17	2	2 1.7
18	2	2 1.7
19	1	1 .8
20	6	6 5.1
COLUMN TOTAL	118 100.0	118 100.0

NUMBER OF MISSING OBSERVATIONS = 280

Table 112

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

CORPS AFFILIATION

BY TYPE OF PROVIDER

		TYPE	
	COUNT	PROFES-SIONAL	ROW TOTAL
H5		41	
	1	21	21
AMSC-CIV			14.3
	3	123	123
MC-CIV			83.7
	4	3	3
MSC-CIV			2.0
	COLUMN TOTAL	147 100.0	147 100.0

NUMBER OF MISSING OBSERVATIONS = 251

Table 113

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

NUMBER OF YEARS WORKED WITH ARMY INPATIENT

MEDICAL RECORDS/DOCUMENTATION

BY TYPE OF PROVIDER

H6	TYPE				
COUNT	RNS (1)	PARA (2)	WARD CLERK (3)	PROFES-SIONAL (4)	ROW TOTAL
1	28	9	1	17	55
					16.6
2	25	16	6	21	68
					20.5
3	4	6		16	26
					7.9
4	5	4		11	20
					6.0
5	3	5	3	4	15
					4.5
6	7	7		5	19
					5.7
7	3	3		10	16
					4.8
8	7	5		6	18
					5.4
9	2			4	6
					1.8
10	5	6	4	7	22
					6.6
11		2		4	6
					1.8
12	5	3		6	14
					4.2
13	2	1	1	2	6
					1.8

Table 113

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

NUMBER OF YEARS WORKED WITH ARMY INPATIENT

MEDICAL RECORDS/DOCUMENTATION

BY TYPE OF PROVIDER (CONTINUED)

H6 COUNT / TYPE	IRNS (1)	PARA (2)	WARD CLERK (3)	PROFESSIONAL (4)	ROW TOTAL
14	4	1		3	8
					2.4
15	6	1		4	11
					3.3
16	2			1	3
					.9
17	2			2	4
					1.2
18	4	1		3	8
					2.4
19				2	2
					.6
20	1	2		1	4
					1.2
COLUMN TOTAL	115	72	15	129	331
	34.7	21.8	4.5	39.0	100.0

NUMBER OF MISSING OBSERVATIONS = 67

Table 114

FITZSIMONS ARMY MEDICAL CENTER

CLINICAL NURSING RECORDS STUDY

FINAL GENERAL COMMENTS

BY TYPE OF PROVIDER

COMMENTS	COUNT / ROW PCT / COL PCT / TAB PCT	TYPE IRN 1	PARA 2	WARD CLERK 3	PROFES-SIONAL 4	ROW TOTAL
45		4	6	5	2	17
GEN+SYS CHG CMTS		23.5	35.3	29.4	11.8	54.8
		80.0	42.9	83.3	33.3	
		12.9	19.4	16.1	6.5	
46		0	0	1	1	2
GEN -CMTS,OLD BETTR		.0	.0	50.0	50.0	6.5
		.0	.0	16.7	16.7	
		.0	.0	3.2	3.2	
48		0	0	0	1	1
REDESIGN COMMENTS		.0	.0	.0	100.0	3.2
		.0	.0	.0	16.7	
		.0	.0	.0	3.2	
49		1	0	0	0	1
SPECIFIC AREA PROBS		100.0	.0	.0	.0	3.2
		20.0	.0	.0	.0	
		3.2	.0	.0	.0	
50		1	8	0	2	11
TDS WANT YELLOW HL		9.1	72.7	.0	18.2	35.5
		20.0	57.1	.0	33.3	
		3.2	25.8	.0	6.5	
COLUMN TOTAL		5	14	6	6	31
		16.1	45.2	19.4	19.4	100.0

PERCENTS AND TOTALS BASED ON RESPONDENTS

31 VALID CASES; 235 MISSING CASES

APPENDIX L

CNR Study Test Site Personnel Survey Responses

Fort Jackson, North Carolina

Table 1

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

TYPE OF RESPONDENT

VALUE LABEL	VALUE	FREQUENCY	PERCENT	VALID PERCENT	CUM PERCENT
RNS	1	65	38.2	38.2	38.2
PARA	2	67	39.4	39.4	77.6
WARD CLERK	3	4	2.4	2.4	80.0
PROFES- SIONAL	4	34	20.0	20.0	100.0
	TOTAL	170	100.0	100.0	

VALID CASES 170 MISSING CASES 0

Table 2

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

"COMPARED TO THE OLD SYSTEM, I FEEL THE TEST FORMS SAVE ME NURSING DOCUMENTATION TIME" BY TYPE OF PROVIDER

A1 / COUNT	TYPE: RNS (1)	PARA (2)	ROW TOTAL
1 STRONGLY AGREE	24	21	45
			35.4
2 AGREE	29	33	62
			48.8
3 DISAGREE	9	6	15
			11.8
4 STRONGLY DISAGRE	2	3	5
			3.9
COLUMN TOTAL	64	63	127
	50.4	49.6	100.0

NUMBER OF MISSING OBSERVATIONS = 43

Table 3

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

"COMPARED TO THE OLD SYSTEM, I FEEL THE TEST FORMS HELP AVOID WRITING SAME INFORMATION SEVERAL PLACES"

BY TYPE OF PROVIDER

A2	COUNT	TYPE 1 IRNS	PARA 2	WARD CLERK 3	ROW TOTAL
1 STRONGLY AGREE		22	29	3	54
					41.5
2 AGREE		30	25		55
					42.3
3 DISAGREE		8	9		17
					13.1
4 STRONGLY DISAGRE		3	1		4
					3.1
	COLUMN TOTAL	63	64	3	130
		48.5	49.2	2.3	100.0

NUMBER OF MISSING OBSERVATIONS = 40

Table 4

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

"COMPARED TO THE OLD SYSTEM, I FEEL THE TEST FORMS IMPROVE COMMUNICATIONS ABOUT THE PATIENT AMONG NURSING PERSONNEL"

BY TYPE OF PROVIDER

A3	TYPE IRNS (1)	PARA (2)	ROW TOTAL
1 STRONGLY AGREE	9	16	25
			20.0
2 AGREE	35	35	70
			56.0
3 DISAGREE	16	9	25
			20.0
4 STRONGLY DISAGRE	3	2	5
			4.0
COLUMN TOTAL	63	62	125
	50.4	49.6	100.0

NUMBER OF MISSING OBSERVATIONS = 45

Table 5

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

"COMPARED TO THE OLD SYSTEM, I FEEL THE TEST FORMS IMPROVE COMMUNICATIONS ABOUT THE PATIENT BETWEEN NURSING AND OTHER HEALTH CARE PROFESSIONALS"

BY TYPE OF PROVIDER

A4	COUNT	TYPE IRNS (1)	PARA (2)	ROW TOTAL
STRONGLY AGREE	1	9	16	25
				20.0
AGREE	2	35	36	71
				56.8
DISAGREE	3	15	10	25
				20.0
STRONGLY DISAGRE	4	4		4
				3.2
	COLUMN TOTAL	63	62	125
		50.4	49.6	100.0

NUMBER OF MISSING OBSERVATIONS = 45

Table 6

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

"COMPARED TO THE OLD SYSTEM, I FEEL THE TEST FORMS ENCOURAGE ME TO USE THE NURSING PROCESS"

BY TYPE OF PROVIDER

A5	COUNT	TYPE IRNS	ROW TOTAL
		1	
	1	10	10
STRONGLY AGREE			15.9
	2	34	34
AGREE			54.0
	3	18	18
DISAGREE			28.6
	4	1	1
STRONGLY DISAGRE			1.6
	COLUMN TOTAL	63 100.0	63 100.0

NUMBER OF MISSING OBSERVATIONS = 107

Table 7

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

"COMPARED TO THE OLD SYSTEM, I FEEL THE TEST FORMS ARE EASIER TO USE"

BY TYPE OF PROVIDER

A6	TYPE IRNS (1)	PARA (2)	WARD CLERK (3)	ROW TOTAL
1 STRONGLY AGREE	12	18	2	32 24.8
2 AGREE	38	38	1	77 59.7
3 DISAGREE	12	6		18 14.0
4 STRONGLY DISAGRE	2			2 1.6
COLUMN TOTAL	64 49.6	62 48.1	3 2.3	129 100.0

NUMBER OF MISSING OBSERVATIONS = 41

Table 8

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

"COMPARED TO THE OLD SYSTEM, I FEEL THE TEST FORMS SHOULD HAVE BEEN A MORE DRASTIC CHANGE"

BY TYPE OF PROVIDER

A7	COUNT / TYPE	IRNS (1)	PARA (2)	WARD CLERK (3)	ROW TOTAL
1	STRONGLY AGREE	4	5		9
					7.5
2	AGREE	12	22	1	35
					29.2
3	DISAGREE	34	30	1	65
					54.2
4	STRONGLY DISAGREE	8	3		11
					9.2
	COLUMN TOTAL	58	60	2	120
		48.3	50.0	1.7	100.0

NUMBER OF MISSING OBSERVATIONS = 50

Table 9

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

"COMPARED TO THE OLD SYSTEM, I FEEL THE TEST FORMS ARE A DEFINITE IMPROVEMENT"

BY TYPE OF PROVIDER

AB	COUNT	TYPE IRNS 1	PARA 2	WARD CLERK 3	ROW TOTAL
1	STRONGLY AGREE	13	18	3	34
					26.6
2	AGREE	38	36	1	75
					58.6
3	DISAGREE	9	8		17
					13.3
4	STRONGLY DISAGRE	2			2
					1.6
	COLUMN TOTAL	62	62	4	128
		48.4	48.4	3.1	100.0

NUMBER OF MISSING OBSERVATIONS = 42

Table 10

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

"COMPARED TO THE OLD SYSTEM, I FEEL THE TEST FORMS PROVIDE ME A BETTER PICTURE OF WHAT IS HAPPENING TO THE PATIENT"

BY TYPE OF PROVIDER

A9	COUNT	TYPE IRNS (1)	PARA (2)	ROW TOTAL
STRONGLY AGREE	1	8	13	21 17.1
AGREE	2	33	37	70 56.9
DISAGREE	3	20	11	31 25.2
STRONGLY DISAGRE	4	1		1 .8
	COLUMN TOTAL	62 50.4	61 49.6	123 100.0

NUMBER OF MISSING OBSERVATIONS = 47

Table 11

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

"COMPARED TO THE OLD SYSTEM, I FEEL THE TEST FORMS

REDUCE THE AMOUNT OF PAPERWORK I HAVE TO DO"

BY TYPE OF PROVIDER

	TYPE			
COUNT	IRNS	PARA	WARD CLERK	ROW TOTAL
AID	1	2	3	
1 STRONGLY AGREE	12	16	1	29 / 22.7
2 AGREE	30	32	2	64 / 50.0
3 DISAGREE	16	13		29 / 22.7
4 STRONGLY DISAGRE	5	1		6 / 4.7
COLUMN TOTAL	63 / 49.2	62 / 48.4	3 / 2.3	128 / 100.0

NUMBER OF MISSING OBSERVATIONS = 42

Table 12

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

"COMPARED TO THE OLD SYSTEM, I FEEL THE TEST FORMS HAVE IMPROVED THE QUALITY OF DOCUMENTATION ON MY NURSING UNIT"

BY TYPE OF PROVIDER

		TYPE		
	COUNT	IRNS	PARA	ROW TOTAL
		11	21	
All	1	11	11	22
	STRONGLY AGREE			18.0
	2	22	40	62
	AGREE			50.8
	3	24	10	34
	DISAGREE			27.9
	4	3	1	4
	STRONGLY DISAGRE			3.3
	COLUMN TOTAL	60	62	122
		49.2	50.8	100.0

NUMBER OF MISSING OBSERVATIONS = 48

Table 13

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

"THE NUMBER OF NURSING HISTORY QUESTIONS IS ADEQUATE"

BY TYPE OF PROVIDER

B1	COUNT	TYPE IRNS (1)	PARA (2)	ROW TOTAL
1 STRONGLY AGREE	1	12	12	24
		20.2		
AGREE	2	42	38	80
		67.2		
DISAGREE	3	5	9	14
		11.8		
STRONGLY DISAGRE	4	1		1
		.8		
	COLUMN TOTAL	60	59	119
		50.4	49.6	100.0

NUMBER OF MISSING OBSERVATIONS = 51

Table 14

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

"THE CONTENT OF THE NURSING HISTORY QUESTIONS IS AS THOROUGH AS I NEED THEM TO BE"

BY TYPE OF PROVIDER

B2	COUNT	TYPE 1 IRNS	2 PARA	ROW TOTAL
1 STRONGLY AGREE		7	9	16
		13.7		
2 AGREE		43	38	81
		69.2		
3 DISAGREE		8	11	19
		16.2		
4 STRONGLY DISAGRE		1		1
		.9		
	COLUMN TOTAL	59	58	117
		50.4	49.6	100.0

NUMBER OF MISSING OBSERVATIONS = 53

Table 15

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

"ON MY NURSING UNIT THE BLOCK FOR PATIENT'S PERSONAL ARTICLES AND VALUABLES IS HELPFUL"

BY TYPE OF PROVIDER

B3	COUNT	TYPE IRNS 1	PARA 2	WARD CLERK 3	ROW TOTAL
1 STRONGLY AGREE	1	6	12	2	20
					16.0
2 AGREE	2	39	42		81
					64.8
3 DISAGREE	3	13	7		20
					16.0
4 STRONGLY DISAGRE	4	2	1	1	4
					3.2
	COLUMN TOTAL	60	62	3	125
		48.0	49.6	2.4	100.0

NUMBER OF MISSING OBSERVATIONS = 45

Table 16

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

"ON MY NURSING UNIT MOST NURSING HISTORIES ARE DONE BY NON-RN/ANC PERSONNEL."

BY TYPE OF PROVIDER

B4	COUNT	TYPE 1 IRNS	2 PARA	3 WARD CLERK	ROW TOTAL
1 STRONGLY AGREE		6	16	2	24
					18.9
2 AGREE		25	24	1	50
					39.4
3 DISAGREE		20	16		36
					28.3
4 STRONGLY DISAGRE		11	6		17
					13.4
	COLUMN TOTAL	62	62	3	127
		48.8	48.8	2.4	100.0

NUMBER OF MISSING OBSERVATIONS = 43

Table 17

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

"ON MY NURSING UNIT ALL NURSING ASSESSMENTS ARE DONE BY RNs AND ANCs"

BY TYPE OF PROVIDER

B5	COUNT	TYPE RNS (1)	PARA (2)	WARD CLERK (3)	ROW TOTAL
1 STRONGLY AGREE	1	40	20	3	63
					48.8
2 AGREE	2	17	26		43
					33.3
3 DISAGREE	3	5	14	1	20
					15.5
4 STRONGLY DISAGRE	4		3		3
					2.3
	COLUMN TOTAL	62	63	4	129
		48.1	48.8	3.1	100.0

NUMBER OF MISSING OBSERVATIONS = 41

Table 18

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

"ON MY NURSING UNIT AN OVERPRINT IS USED FOR THE ASSESSMENT"

BY TYPE OF PROVIDER

B6	COUNT	TYPE IRNS 11	ROW TOTAL
STRONGLY AGREE	1	6	6 10.2
AGREE	2	14	14 23.7
DISAGREE	3	27	27 45.8
STRONGLY DISAGREE	4	12	12 20.3
	COLUMN TOTAL	59 100.0	59 100.0

NUMBER OF MISSING OBSERVATIONS = 111

Table 19

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

"ON MY NURSING UNIT WE OFTEN USE THE HISTORY AND ASSESSMENT CONTINUATION SHEET"

BY TYPE OF PROVIDER

B7	TYPE COUNT	1 IRNS	PARA 2	WARD CLERK 3	ROW TOTAL
1 STRONGLY AGREE		3	5	1	9 7.5
2 AGREE		15	30	1	46 38.3
3 DISAGREE		30	18	1	49 40.8
4 STRONGLY DISAGRE		13	2	1	16 13.3
	COLUMN TOTAL	61 50.8	55 45.8	4 3.3	120 100.0

NUMBER OF MISSING OBSERVATIONS = 50

Table 20

FORT JACKSON

CLINIC NURSING RECORDS STUDY

"OVERPRINTING THE ASSESSMENT CATEGORIES FROM THE STANDARDS OF NURSING PRACTICE (DA PAM 40-5) IS HELPFUL TO ME"

BY TYPE OF PROVIDER

B8	COUNT	TYPE IRNS 1	ROW TOTAL
STRONGLY AGREE	1	13	13 24.5
AGREE	2	24	24 45.3
DISAGREE	3	9	9 17.0
STRONGLY DISAGRE	4	7	7 13.2
	COLUMN TOTAL	53 100.0	53 100.0

NUMBER OF MISSING OBSERVATIONS = 117

Table 21

FORT JACKSON

CLINIC NURSING RECORDS STUDY

"OVERPRINTING THE ASSESSMENT CATEGORIES FROM THE STANDARDS OF NURSING PRACTICE (DA PAM 40-5) HAS INCREASED MY USE OF THE CATEGORIES"

BY TYPE OF PROVIDER

B9	COUNT	TYPE IRNS 11	ROW TOTAL
STRONGLY AGREE	1	9	9 17.3
AGREE	2	25	25 48.1
DISAGREE	3	12	12 23.1
STRONGLY DISAGREE	4	6	6 11.5
	COLUMN TOTAL	52 100.0	52 100.0

NUMBER OF MISSING OBSERVATIONS = 118

Table 22

FORT JACKSON

CLINIC NURSING RECORDS STUDY

"OVERPRINTING THE ASSESSMENT CATEGORIES FROM THE

STANDARDS OF NURSING PRACTICE (DA PAM 40-5)

SHOULD BE CONTINUED"

BY TYPE OF PROVIDER

	TYPE	
COUNT	IRNS	ROW TOTAL
B10	11	
1 STRONGLY AGREE	12	12
		23.1
2 AGREE	25	25
		48.1
3 DISAGREE	10	10
		19.2
4 STRONGLY DISAGRE	5	5
		9.6
COLUMN TOTAL	52	52
	100.0	100.0

NUMBER OF MISSING OBSERVATIONS = 118

Table 23

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

"I LIKE THE IDEA OF THE NURSING HISTORY AND ASSESSMENT, IF COMPLETED ON ADMISSION, SERVING AS THE ADMISSION NURSING NOTE"

BY TYPE OF PROVIDER

B11	COUNT	TYPE I IRNS I II	ROW TOTAL
STRONGLY AGREE	1	37	37
			61.7
AGREE	2	20	20
			33.3
DISAGREE	3	2	2
			3.3
STRONGLY DISAGRE	4	1	1
			1.7
	COLUMN TOTAL	60 100.0	60 100.0

NUMBER OF MISSING OBSERVATIONS = 110

Table 24

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

"OVERPRINTING THE NURSING DIAGNOSES ONTO THE CARE PLAN

IS HELPFUL TO ME"

BY TYPE OF PROVIDER

B12	COUNT	TYPE IRNS 11	ROW TOTAL
1 STRONGLY AGREE	1	27	27
			46.6
2 AGREE	2	25	25
			43.1
3 DISAGREE	3	5	5
			8.6
4 STRONGLY DISAGRE	4	1	1
			1.7
	COLUMN TOTAL	58 100.0	58 100.0

NUMBER OF MISSING OBSERVATIONS = 112

Table 25

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

"OVERPRINTING THE NURSING DIAGNOSES ONTO THE CARE PLAN HAS INCREASED MY USE OF THE DIAGNOSES"

BY TYPE OF PROVIDER

B13	COUNT	TYPE IRNS	RDN	TOTAL
1 STRONGLY AGREE	1	24		24
				42.9
2 AGREE	2	23		23
				41.1
3 DISAGREE	3	8		8
				14.3
4 STRONGLY DISAGRE	4	1		1
				1.8
	COLUMN TOTAL	56		56
		100.0		100.0

NUMBER OF MISSING OBSERVATIONS = 114

Table 26

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

"OVERPRINTING THE NURSING DIAGNOSES ONTO THE CARE PLAN SHOULD BE CONTINUED"

BY TYPE OF PROVIDER

B14	COUNT	TYPE IRNS	ROW TOTAL
1 STRONGLY AGREE	1	28	28 47.5
2 AGREE	2	25	25 42.4
3 DISAGREE	3	5	5 8.5
4 STRONGLY DISAGRE	4	1	1 1.7
	COLUMN TOTAL	59 100.0	59 100.0

NUMBER OF MISSING OBSERVATIONS = 111

Table 27

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

"I READ THE NURSING CARE PLAN TO LEARN THE OVERALL GOALS FOR THE PATIENT"

BY TYPE OF PROVIDER

B15	COUNT	TYPE PARA 2	ROW TOTAL
1 STRONGLY AGREE	1	16	16
			25.8
2 AGREE	2	42	42
			67.7
3 DISAGREE	3	3	3
			4.8
4 STRONGLY DISAGRE	4	1	1
			1.6
	COLUMN TOTAL	62	62
		100.0	100.0

NUMBER OF MISSING OBSERVATIONS = 108

Table 28

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

"OTHER THAN THE PATIENT IDENTIFICATION STAMP, I HAVE COMPLETED SOME PORTIONS OF THE NURSING DISCHARGE SUMMARY FOR THE NURSES"

BY TYPE OF PROVIDER

C1	COUNT	TYPE 2 PARA	3 WARD CLERK	RDN TOTAL
1 STRONGLY AGREE		11		11
				17.2
2 AGREE		22	1	23
				35.9
3 DISAGREE		24		24
				37.5
4 STRONGLY DISAGRE		4	2	6
				9.4
	COLUMN TOTAL	61	3	64
		95.3	4.7	100.0

NUMBER OF MISSING OBSERVATIONS = 106

Table 29

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

"OTHER THAN THE PATIENT IDENTIFICATION STAMP, THE ENTIRE NURSING DISCHARGE SUMMARY IS COMPLETED ONLY BY AN RN/ANC ON MY NURSING UNIT"

BY TYPE OF PROVIDER

C2	COUNT / TYPE	PARA 21	WARD CLERK 31	ROW TOTAL
STRONGLY AGREE	1	11	2	13
				20.0
AGREE	2	25	1	26
				40.0
DISAGREE	3	18		18
				27.7
STRONGLY DISAGRE	4	8		8
				12.3
	COLUMN TOTAL	62	3	65
		95.4	4.6	100.0

NUMBER OF MISSING OBSERVATIONS = 105

Table 30

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

"NURSING DISCHARGE SUMMARY (DA FORM 3888-5 TEST) - ELEMENTS ON THE FORM ARE THOSE I WOULD INCLUDE IN A DISCHARGE NURSING NOTE"

BY TYPE OF PROVIDER

C3	COUNT	TYPE IRNS II	ROW TOTAL
STRONGLY AGREE	1	19	19
			30.6
AGREE	2	40	40
			64.5
DISAGREE	3	2	2
			3.2
STRONGLY DISAGRE	4	1	1
			1.6
	COLUMN TOTAL	62 100.0	62 100.0

NUMBER OF MISSING OBSERVATIONS = 108

Table 31

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

"NURSING DISCHARGE SUMMARY (DA FORM 3888-5 TEST) - I LIKE TO HAVE THE DISCHARGE SUMMARY SERVE AS THE NURSING DISCHARGE NOTE"

BY TYPE OF PROVIDER

C4	COUNT	TYPE IRNS 11	ROW TOTAL
STRONGLY AGREE	1	31	31
			50.0
AGREE	2	27	27
			43.5
DISAGREE	3	3	3
			4.8
STRONGLY DISAGRE	4	1	1
			1.6
	COLUMN TOTAL	62 100.0	62 100.0

NUMBER OF MISSING OBSERVATIONS = 108

Table 32

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

"NURSING DISCHARGE SUMMARY (DA FORM 3888-5 TEST) -

IT IS HELPFUL TO HAVE A COPY FOR THE PATIENT"

BY TYPE OF PROVIDER

C5	COUNT	TYPE IRNS	ROW TOTAL
STRONGLY AGREE	1	30	30 48.4
AGREE	2	29	29 46.8
DISAGREE	3	2	2 3.2
STRONGLY DISAGRE	4	1	1 1.6
	COLUMN TOTAL	62 100.0	62 100.0

NUMBER OF MISSING OBSERVATIONS = 108

Table 33

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

"NURSING DISCHARGE SUMMARY (DA FORM 3888-5 TEST) - IT IS IMPORTANT FOR A NURSING SUMMARY TO APPEAR IN THE OUTPATIENT RECORD"

BY TYPE OF PROVIDER

C6	COUNT	TYPE IRNS 11	ROW TOTAL
1 STRONGLY AGREE	1	23	23
			38.3
AGREE	2	26	26
			43.3
DISAGREE	3	8	8
			13.3
STRONGLY DISAGRE	4	3	3
			5.0
	COLUMN TOTAL	60	60
		100.0	100.0

NUMBER OF MISSING OBSERVATIONS = 110

Table 34

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

"NURSING DISCHARGE SUMMARY (DA FORM 3888-5 TEST) - THE NURSING DISCHARGE SUMMARY FORM NEEDS TO BE KEPT IN THE SYSTEM"

BY TYPE OF PROVIDER

C7	COUNT	TYPE IRNS 11	ROW TOTAL
STRONGLY AGREE	1	23	23
			37.1
AGREE	2	37	37
			59.7
DISAGREE	3	1	1
			1.6
STRONGLY DISAGRE	4	1	1
			1.6
	COLUMN TOTAL	62	62
		100.0	100.0

NUMBER OF MISSING OBSERVATIONS = 108

Table 35

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

"NURSING DISCHARGE SUMMARY (DA FORM 3888-5 TEST) - DISCHARGE SUMMARIES SHOULD BE IN A MULTIDISCIPLINARY FORMAT SO PHYSICIANS AND OTHER HEALTH CARE PROVIDERS COULD MAKE APPROPRIATE NOTATIONS"

BY TYPE OF PROVIDER

CB	COUNT	TYPE IRNS 1	ROW TOTAL
STRONGLY AGREE	1	19	19 31.1
AGREE	2	23	23 37.7
DISAGREE	3	12	12 19.7
STRONGLY DISAGRE	4	7	7 11.5
	COLUMN TOTAL	61 100.0	61 100.0

NUMBER OF MISSING OBSERVATIONS = 109

Table 36

FORT JACKSON

CINICAL NURSING RECORDS STUDY

"DOCTOR'S ORDERS MEDICATION/DOCTOR'S ORDERS NONMEDICATION

(DA FORM 4256-1 TEST; DA FORM 4256-2 TEST) -

WE FREQUENTLY USE THE BUFF COPY ON

NURSING UNIT"

BY TYPE OF PROVIDER

D1	COUNT / TYPE	IRNS 1	PARA 2	WARD CLERK 3	ROW TOTAL
1	STRONGLY AGREE	11	8	2	21
					17.9
2	AGREE	23	29	1	53
					45.3
3	DISAGREE	20	11	1	32
					27.4
4	STRONGLY DISAGRE	5	6		11
					9.4
	COLUMN TOTAL	59	54	4	117
		50.4	46.2	3.4	100.0

NUMBER OF MISSING OBSERVATIONS = 53

Table 37

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

"DOCTOR'S ORDERS MEDICATION/DOCTOR'S ORDERS NONMEDICATION

(DA FORM 4256-1 TEST; DA FORM 4256-2 TEST) - I LIKE

NOT HAVING TO RECOPY SOME SINGLE ACTION ORDERS

ONTO THE THERAPEUTIC DOCUMENTATION CARE

PLAN"

BY TYPE OF PROVIDER

D2	COUNT	TYPE IRNS 1	PARA 2	WARD CLERK 3	ROW TOTAL
1 STRONGLY AGREE	1	28	18	2	48
					39.0
2 AGREE	2	25	33	2	60
					48.8
3 DISAGREE	3	6	5		11
					8.9
4 STRONGLY DISAGRE	4	4			4
					3.3
	COLUMN TOTAL	63	56	4	123
		51.2	45.5	3.3	100.0

NUMBER OF MISSING OBSERVATIONS = 47

Table 38

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

"DURING THE TEST PERIOD, HOW OFTEN DID YOU USE THE NURSING HISTORY AND ASSESSMENT TO LEARN ABOUT NURSING ACTIVITIES AND THE PATIENT'S CONDITION?"

BY TYPE OF PROVIDER

X1A	COUNT / TYPE: PROFESSIONAL	ROW TOTAL
1 EVERY PNT	1	1 3.3
2 MOST PNTS	7	7 23.3
3 RARELY	15	15 50.0
4 NEVER	7	7 23.3
COLUMN TOTAL	30 100.0	30 100.0

NUMBER OF MISSING OBSERVATIONS = 140

Table 39

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

"DURING THE TEST PERIOD, HOW OFTEN DID YOU USE THE NURSING CARE PLAN TO LEARN ABOUT NURSING ACTIVITY AND THE PATIENT'S CONDITION?"

BY TYPE OF PROVIDER

X1B	COUNT / TYPE	PROFESSIONAL (4)	RDN	TOTAL
2		3		3
MOST PNTS				10.0
3		13		13
RARELY				43.3
4		14		14
NEVER				46.7
	COLUMN TOTAL	30		30
		100.0		100.0

NUMBER OF MISSING OBSERVATIONS = 140

Table 40

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

"DURING THE TEST PERIOD, HOW OFTEN DID YOU USE THE NURSING DISCHARGE SUMMARY TO LEARN ABOUT NURSING ACTIVITIES AND THE PATIENT'S CONDITION?"

BY TYPE OF PROVIDER

X1C	COUNT / TYPE	PROFESSIONAL	ROW TOTAL
		4	
1 EVERY PNT	1	1	1 3.3
2 MOST PNTS	2	4	4 13.3
3 RARELY	3	12	12 40.0
4 NEVER	4	13	13 43.3
	COLUMN TOTAL	30 100.0	30 100.0

NUMBER OF MISSING OBSERVATIONS = 140

Table 41

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

"DURING THE TEST PERIOD, HOW OFTEN DID YOU USE

THE THERAPEUTIC DOCUMENTATION CARE PLAN,

NONMEDICATION?"

BY TYPE OF PROVIDER

X1D	COUNT	TYPE PROFESSIONAL	4	ROW TOTAL
EVERY PNT	1	6		6 18.8
MOST PNTS	2	6		6 18.8
RARELY	3	11		11 34.4
NEVER	4	9		9 28.1
	COLUMN TOTAL	32 100.0		32 100.0

NUMBER OF MISSING OBSERVATIONS = 138

Table 42

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

"DURING THE TEST PERIOD, HOW OFTEN DID YOU USE THE THERAPEUTIC DOCUMENTATION CARE PLAN, MEDICATION?"

BY TYPE OF PROVIDER

X1E	COUNT	TYPE PROFESSIONAL	ROW TOTAL
		41	
EVERY PNT	1	6	6
			18.8
MOST PNTS	2	6	6
			18.8
RARELY	3	14	14
			43.8
NEVER	4	6	6
			18.8
	COLUMN TOTAL	32	32
		100.0	100.0

NUMBER OF MISSING OBSERVATIONS = 138

Table 43

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

"DURING THE TEST PERIOD, HOW OFTEN DID YOU USE THE TPR GRAPHIC?"

BY TYPE OF PROVIDER

X1F	COUNT	TYPE: PROFESSIONAL (4)	ROW TOTAL
1 EVERY PNT	1	23	23
			71.9
2 MOST PNTS	2	4	4
			12.5
3 RARELY	3	1	1
			3.1
4 NEVER	4	4	4
			12.5
	COLUMN TOTAL	32	32
		100.0	100.0

NUMBER OF MISSING OBSERVATIONS = 138

Table 44

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

"DURING THE TEST PERIOD, HOW OFTEN DID YOU USE THE PROGRESS NOTES?"

BY TYPE OF PROVIDER

X16	COUNT	TYPE PROFESSIONAL (41)	ROW TOTAL
EVERY PNT	1	20	20
			62.5
MOST PNTS	2	9	9
			28.1
RARELY	3	2	2
			6.3
NEVER	4	1	1
			3.1
	COLUMN TOTAL	32	32
		100.0	100.0

NUMBER OF MISSING OBSERVATIONS = 138

Table 45

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

"DURING THE TEST PERIOD, HOW OFTEN DID YOU USE THE OTHER FORMS TO REVIEW NURSING CARE?"

BY TYPE OF PROVIDER

X1H	COUNT	TYPE: PROFESSIONAL (1)	ROW TOTAL
MOST PNTS	2	1	1
			20.0
RARELY	3	1	1
			20.0
NEVER	4	3	3
			60.0
COLUMN TOTAL		5	5
		100.0	100.0

NUMBER OF MISSING OBSERVATIONS = 165

Table 46

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

"PRIOR TO THE TEST PERIOD, HOW OFTEN HAD YOU USED THE NURSING HISTORY AND ASSESSMENT TO LEARN ABOUT NURSING ACTIVITIES AND THE PATIENT'S CONDITION?"

BY TYPE OF PROVIDER

		TYPE	
	COUNT	PROFESSIONAL	ROW TOTAL
		41	
X3A			
2		5	5
MOST PNTS			17.2
3		17	17
RARELY			58.6
4		7	7
NEVER			24.1
	COLUMN TOTAL	29	29
		100.0	100.0

NUMBER OF MISSING OBSERVATIONS = 141

Table 47

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

"PRIOR TO THE TEST PERIOD, HOW OFTEN HAD YOU USED THE NURSING CARE PLAN TO LEARN ABOUT NURSING ACTIVITIES AND THE PATIENT'S CONDITION?"

BY TYPE OF PROVIDER

		TYPE	
	COUNT	PROFESSIONAL	ROW TOTAL
		41	
X3B			
	2	1	1
MOST PNTS			3.4
	3	16	16
RARELY			55.2
	4	12	12
NEVER			41.4
	COLUMN TOTAL	29	29
		100.0	100.0

NUMBER OF MISSING OBSERVATIONS = 141

Table 48

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

"PRIOR TO THE TEST PERIOD, HOW OFTEN HAD YOU USED THE NURSING DISCHARGE SUMMARY TO LEARN ABOUT NURSING ACTIVITIES AND THE PATIENT'S CONDITION?"

BY TYPE OF PROVIDER

		TYPE	
	COUNT	PROFESSIONAL	ROW TOTAL
		41	
X3C			
1 EVERY PNT	1	1	1
			3.4
2 MOST PNTS	1	1	1
			3.4
3 RARELY	14	14	14
			48.3
4 NEVER	13	13	13
			44.8
COLUMN TOTAL	29	29	
	100.0	100.0	

NUMBER OF MISSING OBSERVATIONS = 141

Table 49

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

"PRIOR TO THE TEST PERIOD, HOW OFTEN HAD YOU USED THE THERAPEUTIC DOCUMENTATION CARE PLAN, NONMEDICATION?"

BY TYPE OF PROVIDER

X3D	COUNT	TYPE PROFESSIONAL	ROW TOTAL
		41	
EVERY PNT	1	1	1
			3.4
MOST PNTS	2	4	4
			13.8
RARELY	3	14	14
			48.3
NEVER	4	10	10
			34.5
	COLUMN TOTAL	29	29
		100.0	100.0

NUMBER OF MISSING OBSERVATIONS = 141

Table 50

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

"PRIOR TO THE TEST PERIOD, HOW OFTEN HAD YOU USED THE THERAPEUTIC DOCUMENTATION CARE PLAN, MEDICATION?"

BY TYPE OF PROVIDER

		TYPE	
	COUNT	PROFESSIONAL	ROW TOTAL
		41	
X3E			
1		1	1
EVERY PNT			3.4
2		4	4
MOST PNTS			13.8
3		16	16
RARELY			55.2
4		8	8
NEVER			27.6
	COLUMN TOTAL	29	29
		100.0	100.0

NUMBER OF MISSING OBSERVATIONS = 141

Table 51

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

"PRIOR TO THE TEST PERIOD, HOW OFTEN HAD YOU USED THE TPR GRAPHIC?"

BY TYPE OF PROVIDER

X3F	COUNT	TYPE PROFESSIONAL 4	ROW TOTAL
EVERY PNT	1	20	20 66.7
MOST PNTS	2	5	5 16.7
RARELY	3	3	3 10.0
NEVER	4	2	2 6.7
	COLUMN TOTAL	30 100.0	30 100.0

NUMBER OF MISSING OBSERVATIONS = 140

Table 52

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

"PRIOR TO THE TEST PERIOD, HOW OFTEN HAD YOU USED THE NURSING NOTES?"

BY TYPE OF PROVIDER

X36	COUNT	TYPE PROFESSIONAL 4	ROW TOTAL
1 EVERY PNT	1	5	5 / 16.7
2 MOST PNTS	2	14	14 / 46.7
3 RARELY	3	9	9 / 30.0
4 NEVER	4	2	2 / 6.7
	COLUMN TOTAL	30 / 100.0	30 / 100.0

NUMBER OF MISSING OBSERVATIONS = 140

Table 53

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

"PRIOR TO THE TEST PERIOD, HOW OFTEN DID YOU USE OTHER FORMS TO REVIEW NURSING CARE?"

BY TYPE OF PROVIDER

		TYPE	
	COUNT	PROFESSIONAL	ROW TOTAL
X3H		4	
3		2	2
RARELY			100.0
	COLUMN TOTAL	2	2
		100.0	100.0

NUMBER OF MISSING OBSERVATIONS = 168

Table 54

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

"DOCTOR'S ORDERS MEDICATION/DOCTOR'S ORDERS NONMEDICATION

(DA FORM 4256-1 TEST; DA FORM 4256-2 TEST) - HAVING

TWO SEPARATE ORDER SHEETS CAUSED MINIMAL

DIFFICULTIES FOR ME"

BY TYPE OF PROVIDER

D3	COUNT / TYPE	IRNS 1	PARA 2	WARD CLERK 3	PROFESSIONAL 4	ROW TOTAL
1	STRONGLY AGREE	9	21	2	5	37
						23.1
2	AGREE	28	32	1	13	74
						46.3
3	DISAGREE	12	5		4	21
						13.1
4	STRONGLY DISAGREE	16	2	1	9	28
						17.5
	COLUMN TOTAL	65	60	4	31	160
		40.6	37.5	2.5	19.4	100.0

NUMBER OF MISSING OBSERVATIONS = 10

Table 55

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

"DOCTOR'S ORDERS MEDICATION/DOCTOR'S ORDERS NONMEDICATION

(DA FORM 4256-1 TEST; DA FORM 4256-2 TEST) - ORDERS

SHOULD CONTINUE TO REMAIN SEPARATED ON COLOR

CODED MEDICATION AND NONMEDICATION SHEETS"

BY TYPE OF PROVIDER

D4	COUNT / TYPE	IRNS 1	PARA 2	WARD CLERK 3	PROFES-SIONAL 4	ROW TOTAL
1 STRONGLY AGREE		20	33	2	4	59
						37.8
2 AGREE		21	24	1	9	55
						35.3
3 DISAGREE		10	2		5	17
						10.9
4 STRONGLY DISAGRE		13	1	1	10	25
						16.0
COLUMN TOTAL		64	60	4	28	156
		41.0	38.5	2.6	17.9	100.0

NUMBER OF MISSING OBSERVATIONS = 14

Table 56

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

"DOCTOR'S ORDERS MEDICATION/DOCTOR'S ORDERS NONMEDICATION (DA FORM 4256-1 TEST; DA FORM 4256-2 TEST) - PRIOR TO THE TEST PERIOD, IF UNFAMILIAR WITH A PATIENT, I MOST OFTEN DETERMINED CURRENT MEDICATION(S) BY . . ."

BY TYPE OF PROVIDER

D6	COUNT	TYPE PROFESSIONAL 4	ROW TOTAL
1 REVIEW ALL DR OR		19 61.3	19 61.3
2 REVIEW TD-MED		7 22.6	7 22.6
3 ASK NURSE		2 6.5	2 6.5
4 OTHER		3 9.7	3 9.7
COLUMN TOTAL		31 100.0	31 100.0

NUMBER OF MISSING OBSERVATIONS = 139

Table 57

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

"DOCTOR'S ORDERS MEDICATION/DOCTOR'S ORDERS NONMEDICATION

(DA FORM 4256-1 TEST; DA FORM 4256-2 TEST) -

DURING THE TEST PERIOD, AFTER THE SEPARATION OF ORDERS,

IF UNFAMILIAR WITH A PATIENT, I MOST OFTEN DETERMINED

CURRENT MEDICATION(S) BY . . ."

BY TYPE OF PROVIDER

		TYPE	
	COUNT	PROFESSIONAL	ROW TOTAL
		41	
D7			
	1	19	19
REVIEW ALL DR OR			61.3
	2	8	8
REVIEW TO-MED			25.8
	3	1	1
ASK NURSE			3.2
	4	3	3
OTHER			9.7
	COLUMN TOTAL	31	31
		100.0	100.0

NUMBER OF MISSING OBSERVATIONS = 139

Table 58

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

"DOCTOR'S ORDERS MEDICATION/DOCTOR'S ORDERS NONMEDICATION

(DA FORM 4256-1 TEST; DA FORM 4256-2 TEST) -

IF WE WENT BACK TO THE 'OLD' ORDER SHEETS, I WOULD

HAVE NO DIFFICULTY IDENTIFYING COMPLETED SINGLE

ACTION ORDERS"

BY TYPE OF PROVIDER

D8	COUNT	TYPE IRNS 1	PARA 2	WARD CLERK 3	ROW TOTAL
1 STRONGLY AGREE	1	11	8		19
					15.3
2 AGREE	2	28	21	1	50
					40.3
3 DISAGREE	3	20	23	2	45
					36.3
4 STRONGLY DISAGRE	4	4	6		10
					8.1
	COLUMN TOTAL	63	58	3	124
		50.8	46.8	2.4	100.0

NUMBER OF MISSING OBSERVATIONS = 46

Table 59

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

"DOCTOR'S ORDERS MEDICATION/DOCTOR'S ORDERS NONMEDICATION

(DA FORM 4256-1 TEST; DA FORM 4256-2 TEST) -

IF WE WENT BACK TO THE 'OLD' ORDER SHEETS, I WOULD STILL

WANT A COLUMN FOR SINGLE ACTION ORDERS TO PRECLUDE

MY HAVING TO RECOPY THEM ONTO THE THERAPEUTIC

DOCUMENTATION CARE PLANS"

BY TYPE OF PROVIDER

D9	COUNT	TYPE IRNS (1)	PARA (2)	WARD CLERK (3)	RON TOTAL
1 STRONGLY AGREE	1	29	16	2	47
					37.6
2 AGREE	2	25	37	1	63
					50.4
3 DISAGREE	3	7	4		11
					8.8
4 STRONGLY DISAGRE	4	2	1	1	4
					3.2
	COLUMN TOTAL	63	58	4	125
		50.4	46.4	3.2	100.0

NUMBER OF MISSING OBSERVATIONS = 45

Table 60

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

I LIKE BEING ABLE TO DOCUMENT (WITH EFFECTIVENESS CODES OR KEY WORDS) THE PATIENT'S RESPONSE DIRECTLY ON THE THERAPEUTIC DOCUMENTATION CARE PLANS"

BY TYPE OF PROVIDER

E1	COUNT / TYPE	IRNS (1)	PARA (2)	ROW TOTAL
1	STRONGLY AGREE	20	13	33
				27.5
2	AGREE	35	42	77
				64.2
3	DISAGREE	5	4	9
				7.5
4	STRONGLY DISAGRE	1		1
				.8
	COLUMN TOTAL	61	59	120
		50.8	49.2	100.0

NUMBER OF MISSING OBSERVATIONS = 50

Table 61

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

"MOST OF MY DOCUMENTATION IS RECORDED ON THE THERAPEUTIC DOCUMENTATION CARE PLANS"

BY TYPE OF PROVIDER

E2	COUNT	TYPE PARA (2)	ROW TOTAL
1 STRONGLY AGREE	1	10	10
			18.2
2 AGREE	2	31	31
			56.4
3 DISAGREE	3	13	13
			23.6
4 STRONGLY DISAGRE	4	1	1
			1.8
COLUMN TOTAL		55	55
		100.0	100.0

NUMBER OF MISSING OBSERVATIONS = 115

Table 62

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

"IN THE PAST, I USED TO DO MOST OF MY DOCUMENTING ON THE NURSING NOTES (SF 510)"

BY TYPE OF PROVIDER

E3	COUNT	TYPE PARA 21	ROW TOTAL
STRONGLY AGREE	1	23	23 37.1
AGREE	2	36	36 58.1
DISAGREE	3	2	2 3.2
STRONGLY DISAGREE	4	1	1 1.6
	COLUMN TOTAL	62 100.0	62 100.0

NUMBER OF MISSING OBSERVATIONS = 108

Table 63

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

"RECORDING THE PATIENT'S RESPONSE ON THE TD CARE PLAN IMPROVES MY DOCUMENTATION OF PATIENT CARE"

BY TYPE OF PROVIDER

E4	COUNT	TYPE IRNS (1)	PARA (2)	ROW TOTAL
1 STRONGLY AGREE		13	16	29
				23.8
2 AGREE		37	38	75
				61.0
3 DISAGREE		11	7	18
				14.8
4 STRONGLY DISAGRE		1		1
				.8
	COLUMN TOTAL	62	61	123
		50.4	49.6	100.0

NUMBER OF MISSING OBSERVATIONS = 47

Table 64

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

"RECORDING THE PATIENT'S RESPONSE ON THE THERAPEUTIC DOCUMENTATION CARE PLAN ENCOURAGES ME TO WRITE MORE NURSING ORDERS TO DESCRIBE NURSING ACTIVITIES WITH THE PATIENT"

BY TYPE OF PROVIDER

E5	COUNT	TYPE IRNS 11	ROW TOTAL
STRONGLY AGREE	1	13	13 21.0
AGREE	2	36	36 58.1
DISAGREE	3	12	12 19.4
STRONGLY DISAGRE	4	1	1 1.6
	COLUMN TOTAL	62 100.0	62 100.0

NUMBER OF MISSING OBSERVATIONS = 108

Table 65

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

"RECORDING THE PATIENT'S RESPONSE ON THE THERAPEUTIC DOCUMENTATION CARE PLAN IMPROVES COMMUNICATION AMONG NURSING PERSONNEL"

BY TYPE OF PROVIDER

E6	COUNT / TYPE	IRNS (11)	PARA (21)	ROW TOTAL
1		13	13	26
STRONGLY AGREE				21.1
2		36	40	76
AGREE				61.8
3		11	8	19
DISAGREE				15.4
4		1	1	2
STRONGLY DISAGRE				1.6
	COLUMN TOTAL	61	62	123
		49.6	50.4	100.0

NUMBER OF MISSING OBSERVATIONS = 47

Table 66

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

"RECORDING THE PATIENT'S RESPONSE ON THE THERAPEUTIC DOCUMENTATION CARE PLAN IMPROVES COMMUNICATION BETWEEN NURSES AND OTHER HEALTH CARE PROVIDERS"

BY TYPE OF PROVIDER

E7	COUNT / TYPE	IRNS (11)	PARA (21)	ROW TOTAL
1		9	10	19
STRONGLY AGREE				15.6
2		32	43	75
AGREE				61.5
3		16	8	24
DISAGREE				19.7
4		3	1	4
STRONGLY DISAGRE				3.3
	COLUMN TOTAL	60	62	122
		49.2	50.8	100.0

NUMBER OF MISSING OBSERVATIONS = 48

Table 67

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

"RECORDING THE PATIENT'S RESPONSE ON THE TD CARE PLAN HAS DECREASED FRAGMENTED DOCUMENTATION IN THE RECORD"

BY TYPE OF PROVIDER

EB	TYPE		
COUNT	IRNS	PARA	ROW TOTAL
	1	2	
1 STRONGLY AGREE	8	7	15
			12.4
2 AGREE	37	44	81
			66.9
3 DISAGREE	8	11	19
			15.7
4 STRONGLY DISAGRE	6		6
			5.0
COLUMN TOTAL	59	62	121
	48.8	51.2	100.0

NUMBER OF MISSING OBSERVATIONS = 49

Table 68

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

"RECORDING THE PATIENT'S RESPONSE ON THE TD CARE PLAN ALLOWS ME TO GIVE A MORE THOROUGH REPORT"

BY TYPE OF PROVIDER

E9	COUNT	TYPE IRNS 11	ROW TOTAL
STRONGLY AGREE	1	10	10
			16.7
AGREE	2	33	33
			55.0
DISAGREE	3	16	16
			26.7
STRONGLY DISAGRE	4	1	1
			1.7
	COLUMN TOTAL	60 100.0	60 100.0

NUMBER OF MISSING OBSERVATIONS = 110

Table 69

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

"RECORDING THE PATIENT'S RESPONSE ON THE TD CARE PLAN GIVES ME A BETTER 'PICTURE' OF WHAT HAPPENED TO THE PATIENT"

BY TYPE OF PROVIDER

E10	COUNT / TYPE	IRNS (1)	PARA (2)	ROW TOTAL
1 STRONGLY AGREE		8	14	22
				17.9
2 AGREE		35	41	76
				61.8
3 DISAGREE		16	7	23
				18.7
4 STRONGLY DISAGRE		2		2
				1.6
COLUMN TOTAL		61	62	123
		49.6	50.4	100.0

NUMBER OF MISSING OBSERVATIONS = 47

Table 70

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

"I DID NOT DOCUMENT PATIENT RESPONSES ON THE THERAPUETIC DOCUMENTATION CARE PLANS"

BY TYPE OF PROVIDER

E11	TYPE		
COUNT	IRNS (1)	PARA (2)	ROW TOTAL
1 STRONGLY AGREE	1	1	2
	1.8		1.8
2 AGREE	5	12	17
	15.5		15.5
3 DISAGREE	36	32	68
	61.8		61.8
4 STRONGLY DISAGRE	16	7	23
	20.9		20.9
COLUMN TOTAL	58	52	110
	52.7	47.3	100.0

NUMBER OF MISSING OBSERVATIONS = 60

Table 71

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

"I HAD MINIMAL DIFFICULTY RECORDING THE PATIENT'S RESPONSES ON THE THERAPEUTIC DOCUMENTATION CARE PLAN"

BY TYPE OF PROVIDER

E12	COUNT	TYPE 11 IRNS	21 PARA	ROW TOTAL
1 STRONGLY AGREE	1	8	6	14
				12.2
AGREE	2	35	43	78
				67.8
DISAGREE	3	12	8	20
				17.4
STRONGLY DISAGRE	4	3		3
				2.6
	COLUMN TOTAL	58 50.4	57 49.6	115 100.0

NUMBER OF MISSING OBSERVATIONS = 55

Table 72

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

"THE EXPANDED USE OF THE THERAPEUTIC DOCUMENTATION CARE PLAN (BEING ABLE TO DOCUMENT RESPONSES) IS A CONCEPT WHICH SHOULD BE AVAILABLE TO ALL NURSING PERSONNEL WORLDWIDE"

BY TYPE OF PROVIDER

E13	COUNT	TYPE 1 IRNS	TYPE 11 PARA	TYPE 21	ROW TOTAL
1 STRONGLY AGREE		16	13		29
					25.0
2 AGREE		35	38		73
					62.9
3 DISAGREE		5	5		10
					8.6
4 STRONGLY DISAGRE		3	1		4
					3.4
	COLUMN TOTAL	59	57		116
		50.9	49.1		100.0

NUMBER OF MISSING OBSERVATIONS = 54

Table 73

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

"THE 'FOLDER' TYPE FORMAT OF THE THERAPEUTIC DOCUMENTATION CARE PLANS IS AN IMPROVEMENT"

BY TYPE OF PROVIDER

E14	COUNT	TYPE IRNS 1	PARA 2	WARD CLERK 3	ROW TOTAL
1 STRONGLY AGREE	1	10	22	3	35
					27.6
2 AGREE	2	35	35	1	71
					55.9
3 DISAGREE	3	14	4		18
					14.2
4 STRONGLY DISAGREE	4	1	2		3
					2.4
	COLUMN TOTAL	60 47.2	63 49.6	4 3.1	127 100.0

NUMBER OF MISSING OBSERVATIONS = 43

Table 74

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

"THE 'FOLDER' TYPE FORMAT OF THE THERAPEUTIC DOCUMENTATION CARE PLANS SHOULD BE KEPT EVEN IF IT CANNOT BE OVERPRINTED WITH ORDERS"

BY TYPE OF PROVIDER

E15	COUNT	TYPE 1 RNS	1 PARA	2 WARD CLERK	3	ROW TOTAL
1 STRONGLY AGREE	1	9	15	2		26
						21.0
2 AGREE	2	34	33	[illegible]		69
						55.6
3 DISAGREE	3	12	9			21
						16.9
4 STRONGLY DISAGREE	4	4	4			8
						6.5
	COLUMN TOTAL	59	61	4		124
		47.6	49.2	3.2		100.0

NUMBER OF MISSING OBSERVATIONS = 46

Table 75

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

"THE 'FOLDER' TYPE FORMAT OF THE THERAPEUTIC DOCUMENTATION CARE PLANS SHOULD HAVE THE PATIENT IDENTIFICATION BLOCK PRINTED ON ALL PAGES"

BY TYPE OF PROVIDER

E16	COUNT	TYPE IRNS 1	PARA 2	WARD CLERK 3	ROW TOTAL
1 STRONGLY AGREE	1	9	19		28
					21.7
2 AGREE	2	28	27		55
					42.6
3 DISAGREE	3	20	15	2	37
					28.7
4 STRONGLY DISAGRE	4	5	2	2	9
					7.0
	COLUMN TOTAL	62 48.1	63 48.8	4 3.1	129 100.0

NUMBER OF MISSING OBSERVATIONS = 41

Table 76

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

"I LIKE THE STURDIER PAPER ON WHICH THE FORMS ARE PRINTED"

BY TYPE OF PROVIDER

E17	COUNT	TYPE IRNS (1)	PARA (2)	WARD CLERK (3)	ROW TOTAL
1 STRONGLY AGREE	1	28	22	3	53
					41.7
2 AGREE	2	26	37	1	64
					50.4
3 DISAGREE	3	5	3		8
					6.3
4 STRONGLY DISAGRE	4	2			2
					1.6
	COLUMN TOTAL	61	62	4	127
		48.0	48.8	3.1	100.0

NUMBER OF MISSING OBSERVATIONS = 43

Table 77

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

"HAVING SEPARATE PAGES FOR RECURRING, DELAYED, OR PRN ACTION ORDERS IS HELPFUL TO ME"

BY TYPE OF PROVIDER

E18	COUNT	TYPE 1 IRNS	PARA	WARD CLERK	ROW TOTAL
		1	11	21	31	
1		18	19	3	39
STRONGLY AGREE					31.7
2		37	33	1	71
AGREE					57.7
3		4	7		11
DISAGREE					8.9
4		2			2
STRONGLY DISAGRE					1.6
	COLUMN TOTAL	61	58	4	123
		49.6	47.2	3.3	100.0

NUMBER OF MISSING OBSERVATIONS = 47

Table 78

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

"TO MY KNOWLEDGE, THERE WERE NO TREATMENT OR MEDICATION ERRORS COMMITTED ON MY NURSING UNIT WHICH COULD BE BLAMED ON THE NEW FORMAT OF THE THERAPEUTIC DOCUMENTATION CARE PLANS"

BY TYPE OF PROVIDER

E19	TYPE IRNS (1)	PARA (11)	PARA (21)	ROW TOTAL
1 STRONGLY AGREE	15	17		32 26.9
2 AGREE	30	31		61 51.3
3 DISAGREE	13	10		23 19.3
4 STRONGLY DISAGRE	3			3 2.5
COLUMN TOTAL	61 51.3	58 48.7		119 100.0

NUMBER OF MISSING OBSERVATIONS = 51

Table 79

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

"I WOULD PREFER TO HAVE THE THERAPEUTIC DOCUMENTATION CARE PLANS IN A SINGLE SHEET FORMAT (LIKE THE 'OLD' TDs) EVEN KNOWING THAT I WOULD HAVE LESS ROOM FOR DOCUMENTATION"

BY TYPE OF PROVIDER

E20	COUNT	TYPE IRNS (1)	PARA (2)	WARD CLERK (3)	ROW TOTAL
1 STRONGLY AGREE		5	1	1	7
					5.8
2 AGREE		2	17	1	20
					16.7
3 DISAGREE		39	34		73
					60.8
4 STRONGLY DISAGRE		13	5	2	20
					16.7
	COLUMN TOTAL	59	57	4	120
		49.2	47.5	3.3	100.0

NUMBER OF MISSING OBSERVATIONS = 50

Table 80

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

"IF A SINGLE SHEET FORMAT WERE TO BE USED, I WOULD PREFER A MEDIUM WEIGHT PAPER (LESS BULKY THAN THE TESTED PAPER)"

BY TYPE OF PROVIDER

E21	TYPE IRNS 1	PARA 2	WARD CLERK 3	ROW TOTAL
1 STRONGLY AGREE	6	1		7 5.9
2 AGREE	9	17	2	28 23.5
3 DISAGREE	37	35	2	74 62.2
4 STRONGLY DISAGRE	6	4		10 8.4
COLUMN TOTAL	58 48.7	57 47.9	4 3.4	119 100.0

NUMBER OF MISSING OBSERVATIONS = 51

Table 81

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

"ALL MEDICATION AND NONMEDICATION FORMS SHOULD REMAIN COLOR CODED"

BY TYPE OF PROVIDER

E22	COUNT	TYPE 1 IRNS	PARA	WARD CLERK	ROW TOTAL
		1	2	3	
1 STRONGLY AGREE		32	33	2	67
					52.8
2 AGREE		26	27	2	55
					43.3
3 DISAGREE		4	1		5
					3.9
	COLUMN TOTAL	62	61	4	127
		48.8	48.0	3.1	100.0

NUMBER OF MISSING OBSERVATIONS = 43

Table 82

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

"YELLOW HIGHLIGHTER USE SHOULD BE REINSTATED TO DISCONTINUE ORDERS"

BY TYPE OF PROVIDER

E23	COUNT	TYPE IRNS 1	PARA 2	WARD CLERK 3	ROW TOTAL
1 STRONGLY AGREE		33	27	2	62
					49.2
2 AGREE		17	25		42
					33.3
3 DISAGREE		8	8	1	17
					13.5
4 STRONGLY DISAGRE		4		1	5
					4.0
	COLUMN TOTAL	62	60	4	126
		49.2	47.6	3.2	100.0

NUMBER OF MISSING OBSERVATIONS = 44

Table 83

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

"THE INTEGRATED PROGRESS NOTE IMPROVES COMMUNICATIONS CONCERNING THE PATIENT AMONG ALL HEALTH CARE PROVIDERS"

BY TYPE OF PROVIDER

F1	TYPE IRNS 1	PARA 2	PROFES-SIONAL 4	ROW TOTAL
1 STRONGLY AGREE	22	22	13	57 36.3
2 AGREE	31	35	11	77 49.0
3 DISAGREE	8	3	6	17 10.8
4 STRONGLY DISAGRE	3	1	2	6 3.8
COLUMN TOTAL	64 40.8	61 38.9	32 20.4	157 100.0

NUMBER OF MISSING OBSERVATIONS = 13

Table 84

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

"THE INTEGRATED PROGRESS NOTE HAS ENCOURAGED ME TO BE MORE THOROUGH IN DOCUMENTATION"

BY TYPE OF PROVIDER

F2	COUNT	TYPE IRNS (1)	PARA (2)	ROW TOTAL
1 STRONGLY AGREE	1	21	19	40
		31.0		
2 AGREE	2	26	44	70
		54.3		
3 DISAGREE	3	15		15
		11.6		
4 STRONGLY DISAGRE	4	3	1	4
		3.1		
	COLUMN TOTAL	65	64	129
		50.4	49.6	100.0

NUMBER OF MISSING OBSERVATIONS = 41

Table 85

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

"THE INTEGRATED PROGRESS NOTE HAS ENCOURAGED ME TO BE MORE CONCISE IN DOCUMENTATION"

BY TYPE OF PROVIDER

F3	COUNT	TYPE IRNS 11	PARA 21	ROW TOTAL
STRONGLY AGREE	1	19	14	33
				26.0
AGREE	2	33	48	81
				63.8
DISAGREE	3	9	1	10
				7.9
STRONGLY DISAGRE	4	3		3
				2.4
	COLUMN TOTAL	64	63	127
		50.4	49.6	100.0

NUMBER OF MISSING OBSERVATIONS = 43

Table 86

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

"THE INTEGRATED PROGRESS NOTE LESSENS FRAGMENTING OF INFORMATION IN THE PATIENT RECORD"

BY TYPE OF PROVIDER

F4	COUNT	TYPE IRNS 1	PARA 2	PROFESSIONAL 4	ROW TOTAL
1 STRONGLY AGREE	1	23	18	13	54
					34.0
2 AGREE	2	33	41	12	86
					54.1
3 DISAGREE	3	6	4	3	13
					8.2
4 STRONGLY DISAGRE	4	2		4	6
					3.8
	COLUMN TOTAL	64	63	32	159
		40.3	39.6	20.1	100.0

NUMBER OF MISSING OBSERVATIONS = 11

Table 87

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

"THE INTEGRATED PROGRESS NOTE LESSENS THE AMOUNT OF INFORMATION EVERYONE MUST DOCUMENT"

BY TYPE OF PROVIDER

F5	COUNT	TYPE IRNS 1	PARA 2	PROFES-SIONAL 4	ROW TOTAL
1 STRONGLY AGREE	1	18	19	4	41
					25.9
2 AGREE	2	33	34	9	76
					48.1
3 DISAGREE	3	10	10	13	33
					20.9
4 STRONGLY DISAGRE	4	3		5	8
					5.1
	COLUMN TOTAL	64 40.5	63 39.9	31 19.6	158 100.0

NUMBER OF MISSING OBSERVATIONS = 12

Table 88

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

"THE INTEGRATED PROGRESS NOTE ENCOURAGES ME TO READ NARRATIVE NURSING NOTES MORE THAN I DID IN THE PAST"

BY TYPE OF PROVIDER

F6	COUNT	TYPE PROFESSIONAL (41)	ROW TOTAL
1 STRONGLY AGREE		12	12
			37.5
2 AGREE		10	10
			31.3
3 DISAGREE		6	6
			18.8
4 STRONGLY DISAGRE		4	4
			12.5
COLUMN TOTAL		32	32
		100.0	100.0

NUMBER OF MISSING OBSERVATIONS = 138

Table 89

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

"THE INTEGRATED PROGRESS NOTE MAKES IT EASIER TO DETERMINE WHAT IS HAPPENING WITH MY PATIENT"

BY TYPE OF PROVIDER

F7	COUNT	TYPE PROFESSIONAL 41	ROW TOTAL
STRONGLY AGREE	1	12	12 38.7
AGREE	2	10	10 32.3
DISAGREE	3	6	6 19.4
STRONGLY DISAGRE	4	3	3 9.7
	COLUMN TOTAL	31 100.0	31 100.0

NUMBER OF MISSING OBSERVATIONS = 139

Table 90

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

"THE INTEGRATED PROGRESS NOTE HAS SAVED ME TIME IN DOCUMENTING

(I FEEL I DON'T NEED TO REPEAT INFORMATION PREVIOUSLY

DOCUMENTED BY ANOTHER HEALTH CARE PROVIDER BECAUSE

IT'S ALL IN THE SAME PLACE)"

BY TYPE OF PROVIDER

F8	COUNT	TYPE IRNS (1)	PARA (2)	ROW TOTAL
1 STRONGLY AGREE		20	21	41
		32.5		
2 AGREE		33	34	67
		53.2		
3 DISAGREE		10	4	14
		11.1		
4 STRONGLY DISAGRE		2	2	4
		3.2		
COLUMN TOTAL		65	61	126
		51.6	48.4	100.0

NUMBER OF MISSING OBSERVATIONS = 44

Table 91

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

"THE INTEGRATED PROGRESS NOTE ENCOURAGES ME TO READ OTHER CARE PROVIDERS' NOTES"

BY TYPE OF PROVIDER

F9	COUNT	TYPE IRNS 11	PARA 21	ROW TOTAL
1 STRONGLY AGREE		23	19	42
				32.8
2 AGREE		35	41	76
				59.4
3 DISAGREE		5	3	8
				6.3
4 STRONGLY DISAGRE		2		2
				1.6
	COLUMN TOTAL	65 50.8	63 49.2	128 100.0

NUMBER OF MISSING OBSERVATIONS = 42

Table 92

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

"THE INTEGRATED PROGRESS NOTE SHOULD BE USED AT ALL ARMY HOSPITALS"

BY TYPE OF PROVIDER

F10	COUNT	TYPE IRNS (1)	PARA (2)	PROFESSIONAL (4)	ROW TOTAL
1 STRONGLY AGREE		28	28	10	66
					42.3
2 AGREE		30	32	11	73
					46.8
3 DISAGREE		3	2	3	8
					5.1
4 STRONGLY DISAGRE		2		7	9
					5.8
COLUMN TOTAL		63	62	31	156
		40.4	39.7	19.9	100.0

NUMBER OF MISSING OBSERVATIONS = 14

Table 93

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

"I HAD LITTLE DIFFICULTY IDENTIFYING WHO WROTE PREVIOUS NARRATIVE NOTATIONS"

BY TYPE OF PROVIDER

F11	COUNT	TYPE PROFESSIONAL 4	ROW TOTAL
STRONGLY AGREE	1	7	7 22.6
AGREE	2	19	19 61.3
DISAGREE	3	1	1 3.2
STRONGLY DISAGRE	4	4	4 12.9
	COLUMN TOTAL	31 100.0	31 100.0

NUMBER OF MISSING OBSERVATIONS = 139

Table 94

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

"I HAD NO DIFFICULTY DISTINGUISHING NURSING NOTATIONS FROM THOSE OF OTHER DISCIPLINES"

BY TYPE OF PROVIDER

F12	COUNT	TYPE IRNS 1	PARA 11	PROFES-SIONAL 21	41	ROW TOTAL
STRONGLY AGREE	1	20	17	9		46
						29.5
AGREE	2	38	39	19		96
						61.5
DISAGREE	3	4	5	2		11
						7.1
STRONGLY DISAGRE	4	2		1		3
						1.9
	COLUMN TOTAL	64	61	31		156
		41.0	39.1	19.9		100.0

NUMBER OF MISSING OBSERVATIONS = 14

Table 95

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

"I HAD LITTLE DIFFICULTY LOCATING MY PREVIOUS NARRATIVE NOTATIONS"

BY TYPE OF PROVIDER

		TYPE	
	COUNT	PROFESSIONAL	ROW TOTAL
F13		4	
1 STRONGLY AGREE	1	7	7 22.6
AGREE	2	17	17 54.8
DISAGREE	3	6	6 19.4
4 STRONGLY DISAGRE	4	1	1 3.2
	COLUMN TOTAL	31 100.0	31 100.0

NUMBER OF MISSING OBSERVATIONS: 139

Table 96

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

"PHYSICIANS ON MY NURSING UNIT SEEMED TO LIKE HAVING NARRATIVE NURSING COMMENTS INTEGRATED WITH OTHER PATIENT CARE DOCUMENTATION"

BY TYPE OF PROVIDER

"I"	TYPE IRNS 1	TYPE PARA 2	ROW TOTAL
1 STRONGLY AGREE	6	8	14
			12.6
2 AGREE	33	40	73
			65.8
3 DISAGREE	11	6	17
			15.3
4 STRONGLY DISAGRE	6	1	7
			6.3
COLUMN TOTAL	56	55	111
	50.5	49.5	100.0

NUMBER OF MISSING OBSERVATIONS 59

Table 97

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

"OTHER HEALTH CARE PROVIDERS (e.g., PHYSICAL THERAPIST, DIETITIAN, SOCIAL WORKER) SEEMED TO LIKE HAVING NARRATIVE NURSING COMMENTS INTEGRATED WITH OTHER PATIENT CARE DOCUMENTATION"

BY TYPE OF PROVIDER

	TYPE		
COUNT	IRNS 1	PARA 2	ROW TOTAL
FIE			
1 STRONGLY AGREE	10	8	18
			16.7
2 AGREE	32	40	72
			66.7
3 DISAGREE	10	6	16
			14.8
4 STRONGLY DISAGREE	2		2
			1.9
COLUMN TOTAL	54	54	108
	50.0	50.0	100.0

NUMBER OF MISSING OBSERVATIONS: 62

Table 98

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

"ALTHOUGH THE GUIDELINES READ THAT ALL NURSING PERSONNEL WERE AUTHORIZED TO CHART ON THE PROGRESS NOTES, THERE WERE SOME EXCEPTIONS TO THIS POLICY ON MY NURSING UNIT"

BY TYPE OF PROVIDER

F16	COUNT / ROW PCT	TYPE: IRNS (1)	TYPE: FARM (2)	ROW TOTAL
1 STRONGLY AGREE		1	10	11
		9.1	90.9	9.3
2 AGREE		8	11	19
		42.1	57.9	16.1
3 DISAGREE		37	28	65
		56.9	43.1	55.1
4 STRONGLY DISAGRE		14	9	23
		60.9	39.1	19.5
COLUMN TOTAL		60	58	118
		50.8	49.2	100.0

NUMBER OF MISSING OBSERVATIONS: 52

Table 99

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

"IN MY OPINION, THE BOTTOM LINE TO EVERYTHING WE HAVE TESTED IS. . ."

BY TYPE OF PROVIDER

TYPE PAGE 1 OF 1

Q1	TYPE: 1 IRNS	2 PARA	3 WARD CLERK	ROW TOTAL
1 IMPLEMENT EXACTL	111	138	14	263
	42.2	52.5	5.3	53.1
	42.5	67.0	50.0	
2 GO BACK TO OLD	3	6	3	12
	25.0	50.0	25.0	2.4
	1.1	2.9	10.7	
3 IMPLEMENT W MODI	147	62	11	220
	66.8	28.2	5.0	44.4
	56.3	30.1	39.3	
COLUMN TOTAL	261	206	28	495
	52.7	41.6	5.7	100.0

NUMBER OF MISSING OBSERVATIONS: 351

Table 100

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

GENERAL COMMENTS REGARDING THE TEST FORMS

BY TYPE OF PROVIDER

COMMENTS	COUNT / ROW PCT / COL PCT / TAB PCT	IRN 1	PARA 2	WARD CLERK 3	PROFES-SIONAL 4	ROW TOTAL
1		2	0	0	2	4
DR ORDER +GEN SAT		50.0	0.0	0.0	50.0	22.2
		40.0	0.0	0.0	50.0	
		11.1	0.0	0.0	11.1	
3		0	1	0	0	1
DR ORD+EASY REFER		0.0	100.0	0.0	0.0	5.6
		0.0	14.3	0.0	0.0	
		0.0	5.6	0.0	0.0	
4		1	0	0	0	1
DR ORD-GEN-PAPERWRK		100.0	0.0	0.0	0.0	5.6
		20.0	0.0	0.0	0.0	
		5.6	0.0	0.0	0.0	
9		0	4	1	0	5
DR ORD 1-SHEET PREFR		0.0	80.0	20.0	0.0	27.8
		0.0	57.1	50.0	0.0	
		0.0	22.2	5.6	0.0	
10		1	1	0	0	2
DR ORD REDISN COMMNT		50.0	50.0	0.0	0.0	11.1
		20.0	14.3	0.0	0.0	
		5.6	5.6	0.0	0.0	
11		2	1	0	3	6
509+ GEN SATISFACT		33.3	16.7	0.0	50.0	33.3
		40.0	14.3	0.0	75.0	
		11.1	5.6	0.0	16.7	
12		0	1	0	0	1
509+IMPROVES COMMUN		0.0	100.0	0.0	0.0	5.6
		0.0	14.3	0.0	0.0	
		0.0	5.6	0.0	0.0	
COLUMN TOTAL		5	7	2	4	18
		27.8	38.9	11.1	22.2	100.0

Table 100

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

GENERAL COMMENTS REGARDING THE TEST FORMS

BY TYPE OF PROVIDER (CONTINUED)

COMMENTS	COUNT / ROW PCT / COL PCT / TAB PCT	IRN 1	PARA 2	WARD CLERK 3	PROFES-SIONAL 4	ROW TOTAL
509- GEN PROBLEMS	14	0	0	1	0	1
		0.0	0.0	100.0	0.0	5.6
		0.0	0.0	50.0	0.0	
		0.0	0.0	5.6	0.0	
509-NOTES QUALITY	20	0	1	0	0	1
		0.0	100.0	0.0	0.0	5.6
		0.0	14.3	0.0	0.0	
		0.0	5.6	0.0	0.0	
509 GO BACK TO SEP N	22	0	2	0	0	2
		0.0	100.0	0.0	0.0	11.1
		0.0	28.6	0.0	0.0	
		0.0	11.1	0.0	0.0	
3888-2 +GEN COMMENT	24	2	1	0	2	5
		40.0	20.0	0.0	40.0	27.8
		40.0	14.3	0.0	50.0	
		11.1	5.6	0.0	11.1	
3888-2 REDESIGN CMTS	26	0	3	1	0	4
		0.0	75.0	25.0	0.0	22.2
		0.0	42.9	50.0	0.0	
		0.0	16.7	5.6	0.0	
3888-2 SPECIFIC PROB	28	1	0	0	0	1
		100.0	0.0	0.0	0.0	5.6
		20.0	0.0	0.0	0.0	
		5.6	0.0	0.0	0.0	
3888-3 + COMMENTS	29	2	1	0	2	5
		40.0	20.0	0.0	40.0	27.8
		40.0	14.3	0.0	50.0	
		11.1	5.6	0.0	11.1	
COLUMN TOTAL		5	7	2	4	18
		27.8	38.9	11.1	22.2	100.0

Table 100

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

GENERAL COMMENTS REGARDING THE TEST FORMS

BY TYPE OF PROVIDER (CONTINUED)

COMMENTS	COUNT / ROW PCT / COL PCT / TAB PCT	IRN 1	PARA 2	WARD CLERK 3	PROFESSIONAL 4	ROW TOTAL
3888-3-NEVER USE	30	2	0	0	0	2
		100.0	0.0	0.0	0.0	11.1
		40.0	0.0	0.0	0.0	
		11.1	0.0	0.0	0.0	
3888-4+ COMMENTS	31	3	1	0	2	6
		50.0	16.7	0.0	33.3	33.3
		60.0	14.3	0.0	50.0	
		16.7	5.6	0.0	11.1	
3888-4 MISC COMMENTS	34	0	1	0	0	1
		0.0	100.0	0.0	0.0	5.6
		0.0	14.3	0.0	0.0	
		0.0	5.6	0.0	0.0	
3888-5+ KEEP	35	3	1	0	2	6
		50.0	16.7	0.0	33.3	33.3
		60.0	14.3	0.0	50.0	
		16.7	5.6	0.0	11.1	
3888-5+REDESIGN CMT	36	0	1	0	1	2
		0.0	50.0	0.0	50.0	11.1
		0.0	14.3	0.0	25.0	
		0.0	5.6	0.0	5.6	
TDS+KEEP,NO CHANGES	40	2	1	0	1	4
		50.0	25.0	0.0	25.0	22.2
		40.0	14.3	0.0	25.0	
		11.1	5.6	0.0	5.6	
TDS REDESIGN COMMNTS	41	0	1	0	0	1
		0.0	100.0	0.0	0.0	5.6
		0.0	14.3	0.0	0.0	
		0.0	5.6	0.0	0.0	
	COLUMN TOTAL	5	7	2	4	18
		27.8	38.9	11.1	22.2	100.0

Table 100

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

GENERAL COMMENTS REGARDING THE TEST FORMS

BY TYPE OF PROVIDER (CONTINUED)

COMMENTS	COUNT / ROW PCT / COL PCT / TAB PCT	TYPE: 1 IRN	2 PARA	3 WARD CLERK	4 PROFESSIONAL	ROW TOTAL
TDS-OLD BETTER	43	0	1	0	0	1
		0.0	100.0	0.0	0.0	5.6
		0.0	14.3	0.0	0.0	
		0.0	5.6	0.0	0.0	
TDS OVERPRINT COMMEN	44	1	0	0	0	1
		100.0	0.0	0.0	0.0	5.6
		20.0	0.0	0.0	0.0	
		5.6	0.0	0.0	0.0	
GEN+SYS CHG CMTS	45	2	0	0	1	3
		66.7	0.0	0.0	33.3	16.7
		40.0	0.0	0.0	25.0	
		11.1	0.0	0.0	5.6	
TDS WANT YELLOW HL	50	0	0	0	3	3
		0.0	0.0	0.0	100.0	16.7
		0.0	0.0	0.0	75.0	
		0.0	0.0	0.0	16.7	
	COLUMN TOTAL	5	7	2	4	18
		27.8	38.9	11.1	22.2	100.0

PERCENTS AND TOTALS BASED ON RESPONDENTS

18 VALID CASES 17 MISSING CASES

Table 101

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

GENERAL COMMENTS REGARDING DA FORM 3888-2 TEST NURSING HISTORY AND ASSESSMENT

BY TYPE OF PROVIDER

	TYPE				
COMMENTS	COUNT / ROW PCT / COL PCT / TAB PCT	IRN 1	PARA 2	WARD CLERK 3	PROFES-SIONAL 4	ROW TOTAL
3888-2 +GEN COMMENT	24	2	1	0	2	5
		40.0	20.0	.0	40.0	50.0
		66.7	25.0	.0	100.0	
		20.0	10.0	.0	20.0	
3888-2 REDESIGN CMTS	26	0	3	1	0	4
		.0	75.0	25.0	.0	40.0
		.0	75.0	100.0	.0	
		.0	30.0	10.0	.0	
3888-2 SPECIFIC PROB	28	1	0	0	0	1
		100.0	.0	.0	.0	10.0
		33.3	.0	.0	.0	
		10.0	.0	.0	.0	
	COLUMN TOTAL	3	4	1	2	10
		30.0	40.0	10.0	20.0	100.0

PERCENTS AND TOTALS BASED ON RESPONDENTS

10 VALID CASES; 25 MISSING CASES

Table 102

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

GENERAL COMMENTS REGARDING DA FORM 3888-3 TEST

NURSING HISTORY AND ASSESSMENT CONTINUATION

BY TYPE OF PROVIDER

		TYPE			
	COUNT ROW PCT COL PCT TAB PCT	IRN 1	PARA 2	PROFES- SIONAL 4	ROW TOTAL
COMMENTS					
3888-3 + COMMENTS	29	2 40.0 50.0 28.6	1 20.0 100.0 14.3	2 40.0 100.0 28.6	5 71.4
3888-3-NEVER USE	30	2 100.0 50.0 28.6	0 .0 .0 .0	0 .0 .0 .0	2 28.6
	COLUMN TOTAL	4 57.1	1 14.3	2 28.6	7 100.0

PERCENTS AND TOTALS BASED ON RESPONDENTS

7 VALID CASES; 28 MISSING CASES

Table 103

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

GENERAL COMMENTS REGARDING DA FORM 3888-4 TEST

NURSING CARE PLAN

BY TYPE OF PROVIDER

	TYPE			
COMMENTS	IRN	PARA	PROFESSIONAL	ROW TOTAL
	1	2	4	
3888-4+ COMMENTS	3	1	2	6
	50.0	16.7	33.3	85.7
	100.0	50.0	100.0	
	42.9	14.3	28.6	
3888-4 MISC COMMENTS	0	1	0	1
	.0	100.0	.0	14.3
	.0	50.0	.0	
	.0	14.3	.0	
COLUMN TOTAL	3	2	2	7
	42.9	28.6	28.6	100.0

PERCENTS AND TOTALS BASED ON RESPONDENTS

7 VALID CASES; 28 MISSING CASES

Table 104

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

GENERAL COMMENTS REGARDING DA FORM 3888-5 TEST

NURSING DISCHARGE SUMMARY

BY TYPE OF PROVIDER

		TYPE			
COMMENTS	COUNT / ROW PCT / COL PCT / TAB PCT	IRN 1	PARA 2	PROFESSIONAL 4	ROW TOTAL
3888-5+ KEEP	35	3	1	2	6
		50.0	16.7	33.3	75.0
		100.0	50.0	66.7	
		37.5	12.5	25.0	
3888-5+REDESIGN CMT	36	0	1	1	2
		.0	50.0	50.0	25.0
		.0	50.0	33.3	
		.0	12.5	12.5	
	COLUMN TOTAL	3	2	3	8
		37.5	25.0	37.5	100.0

PERCENTS AND TOTALS BASED ON RESPONDENTS

8 VALID CASES; 27 MISSING CASES

Table 105

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

GENERAL COMMENTS REGARDING DA FORM 4256-1 TEST DOCTOR'S ORDER SHEET MEDICATION

AND DA FORM 4256-2 TEST DOCTOR'S ORDER SHEET NONMEDICATION

BY TYPE OF PROVIDER

	TYPE				
COMMENTS / COUNT / ROW PCT / COL PCT / TAB PCT	IRN (1)	PARA (2)	WARD CLERK (3)	PROFES-SIONAL (4)	ROW TOTAL
1 DR ORDER +GEN SAT	2	0	0	2	4
	50.0	.0	.0	50.0	30.8
	50.0	.0	.0	100.0	
	15.4	.0	.0	15.4	
3 DR ORD+EASY REFER	0	1	0	0	1
	.0	100.0	.0	.0	7.7
	.0	16.7	.0	.0	
	.0	7.7	.0	.0	
4 DR ORD-GEN-PAPERWRK	1	0	0	0	1
	100.0	.0	.0	.0	7.7
	25.0	.0	.0	.0	
	7.7	.0	.0	.0	
9 DR ORD 1-SHEET PREFR	0	4	1	0	5
	.0	80.0	20.0	.0	38.5
	.0	66.7	100.0	.0	
	.0	30.8	7.7	.0	
10 DR ORD REDISN COMMNT	1	1	0	0	2
	50.0	50.0	.0	.0	15.4
	25.0	16.7	.0	.0	
	7.7	7.7	.0	.0	
COLUMN TOTAL	4	6	1	2	13
	30.8	46.2	7.7	15.4	100.0

PERCENTS AND TOTALS BASED ON RESPONDENTS

13 VALID CASES; 22 MISSING CASES

Table 106

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

GENERAL COMMENTS REGARDING

DA FORM 4677-1 TEST THERAPEUTIC DOCUMENTATION CARE PLAN NONMEDICATION

AND DA FORM 4678-1 TEST THERAPEUTIC DOCUMENTATION CARE PLAN MEDICATION

BY TYPE OF PROVIDER

	TYPE			
COMMENTS	IRN (1)	PARA (2)	PROFESSIONAL (4)	ROW TOTAL
TDS+KEEP,NO CHANGES	2 / 50.0 / 66.7 / 28.6	1 / 25.0 / 33.3 / 14.3	1 / 25.0 / 100.0 / 14.3	4 / 57.1
TDS REDESIGN COMMNTS	0 / .0 / .0 / .0	1 / 100.0 / 33.3 / 14.3	0 / .0 / .0 / .0	1 / 14.3
TDS-OLD BETTER	0 / .0 / .0 / .0	1 / 100.0 / 33.3 / 14.3	0 / .0 / .0 / .0	1 / 14.3
TDS OVERPRINT COMMEN	1 / 100.0 / 33.3 / 14.3	0 / .0 / .0 / .0	0 / .0 / .0 / .0	1 / 14.3
COLUMN TOTAL	3 / 42.9	3 / 42.9	1 / 14.3	7 / 100.0

PERCENTS AND TOTALS BASED ON RESPONDENTS

7 VALID CASES; 28 MISSING CASES

Table 107

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

GENERAL COMMENTS REGARDING INTEGRATED PROGRESS NOTES

BY TYPE OF PROVIDER

COMMENTS	COUNT / ROW PCT / COL PCT / TAB PCT	TYPE: IRN (1)	PARA (2)	WARD CLERK (3)	PROFESSIONAL (4)	ROW TOTAL
11		2	1	0	3	6
509+ GEN SATISFACT		33.3	16.7	.0	50.0	54.5
		100.0	20.0	.0	100.0	
		18.2	9.1	.0	27.3	
12		0	1	0	0	1
509+IMPROVES COMMUN		.0	100.0	.0	.0	9.1
		.0	20.0	.0	.0	
		.0	9.1	.0	.0	
14		0	0	1	0	1
509- GEN PROBLEMS		.0	.0	100.0	.0	9.1
		.0	.0	100.0	.0	
		.0	.0	9.1	.0	
20		0	1	0	0	1
509-NOTES QUALITY		.0	100.0	.0	.0	9.1
		.0	20.0	.0	.0	
		.0	9.1	.0	.0	
22		0	2	0	0	2
509 GO BACK TO SEP N		.0	100.0	.0	.0	18.2
		.0	40.0	.0	.0	
		.0	18.2	.0	.0	
COLUMN TOTAL		2	5	1	3	11
		18.2	45.5	9.1	27.3	100.0

PERCENTS AND TOTALS BASED ON RESPONDENTS

11 VALID CASES; 24 MISSING CASES

Table 108

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

CURRENT DUTY ASSIGNMENT

BY TYPE OF PROVIDER

H1	TYPE		
COUNT	RNS	PARA	ROW TOTAL
	1	2	
1 CLIN STAFF NURSE	47		47
			39.5
2 CLIN HEAD NURSE	7		7
			5.9
3 CLIN NURSE SPEC	1		1
			.8
4 SPEC PRACTICES	5		5
			4.2
5 SECT SUPV	1		1
			.8
6 CH-ASST CH NURSE	1		1
			.8
8 91A-AIDE		14	14
			11.8
9 91B		4	4
			3.4
10 91C PRACT NRS		35	35
			29.4
11 91F-PSYCH TECH		4	4
			3.4
COLUMN TOTAL	62	57	119
	52.1	47.9	100.0

NUMBER OF MISSING OBSERVATIONS = 51

Table 109

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

"ARE YOU A WARDMASTER?"

BY TYPE OF PROVIDER

H2	COUNT	TYPE PARA 2	ROW TOTAL
YES	1	3	3
			5.7
NO	2	50	50
			94.3
	COLUMN TOTAL	53	53
		100.0	100.0

NUMBER OF MISSING OBSERVATIONS = 117

Table 110

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

PRIMARY INPATIENT NURSING UNIT

BY TYPE OF PROVIDER

H3	COUNT	TYPE IRNS 11	PARA 21	WARD CLERK 31	ROW TOTAL
1 SURG UNIT	1	11	9	1	21
					17.4
2 PSYCH UNIT	2	5	7	1	13
					10.7
3 MED UNIT	3	7	8	1	16
					13.2
4 COMBINED MED SUR	4	2	11		13
					10.7
5 PEDS UNIT	5	2	4		6
					5.0
6 ALL ICU S	6	13	11		24
					19.8
7 L&D NBN POST PAR	7	11	6		17
					14.0
8 OR ANES	8	4			4
					3.3
9 OTHER	9	3	3	1	7
					5.8
	COLUMN TOTAL	58	59	4	121
		47.9	48.8	3.3	100.0

NUMBER OF MISSING OBSERVATIONS = 49

Table 111

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

NUMBER OF YEARS WORKED AS A REGISTERED NURSE

BY TYPE OF PROVIDER

H4 COUNT	TYPE IRNS 11	ROW TOTAL
1	5	5
		9.6
2	6	6
		11.5
3	4	4
		7.7
4	3	3
		5.8
5	3	3
		5.8
6	2	2
		3.8
7	3	3
		5.8
8	3	3
		5.8
9	3	3
		5.8
10	1	1
		1.9
11	1	1
		1.9
12	4	4
		7.7
13	1	1
		1.9
14	2	2
		3.8
15	1	1
		1.9
16	3	3
		5.8
17	2	2
		3.8
18	1	1
		1.9
20	4	4
		7.7
COLUMN TOTAL	52	52
	100.0	100.0

NUMBER OF MISSING OBSERVATIONS = 118

Table 112

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

CORPS AFFILIATION

BY TYPE OF PROVIDER

H5	COUNT	TYPE PROFESSIONAL 4	ROW TOTAL
AMSC-CIV	1	4	4 12.1
MC-CIV	3	28	28 84.8
MSC-CIV	4	1	1 3.0
	COLUMN TOTAL	33 100.0	33 100.0

NUMBER OF MISSING OBSERVATIONS = 137

Table 113

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

NUMBER OF YEARS WORKED WITH ARMY INPATIENT

MEDICAL RECORDS/DOCUMENTATION

BY TYPE OF PROVIDER

H6	COUNT / IRNS (1)	PARA (2)	WARD CLERK (3)	PROFESSIONAL (4)	ROW TOTAL
1	13	10	1	2	26
					20.0
2	12	5	1	4	22
					16.9
3	6	4	1	2	13
					10.0
4	1	3			4
					3.1
5	4	2	1	4	11
					8.5
6		5		5	10
					7.7
7	1			3	4
					3.1
8	1	2		3	6
					4.6
9	3	1		2	6
					4.6
10	1	1		2	4
					3.1
12	2	1			3
					2.3
13	1	2			3
					2.3
14		1			1
					.8

(CONTINUED)

Table 113

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

NUMBER OF YEARS WORKED WITH ARMY INPATIENT

MEDICAL RECORDS/DOCUMENTATION

BY TYPE OF PROVIDER (CONTINUED)

H6	TYPE COUNT	1 IRNS	PARA	2 WARD CLERK	3 PROFES-SIONAL	4	ROW TOTAL
	15					2	2
							1.5
	16	1	1				2
							1.5
	17	1					1
							.8
	18	1	1			1	3
							2.3
	19	1				1	2
							1.5
	20	3	4				7
							5.4
	COLUMN TOTAL	52 40.0	43 33.1	4 3.1	31 23.8		130 100.0

NUMBER OF MISSING OBSERVATIONS = 40

Table 114

FORT JACKSON

CLINICAL NURSING RECORDS STUDY

FINAL GENERAL COMMENTS

BY TYPE OF PROVIDER

COMMENTS	COUNT / ROW PCT / COL PCT / TAB PCT	TYPE: IRN (1)	TYPE: PROFESSIONAL (4)	ROW TOTAL
GEN+SYS CHG CMTS	45	2	1	3
		66.7	33.3	60.0
		100.0	33.3	
		40.0	20.0	
TDS WANT YELLOW HL	50	0	3	3
		.0	100.0	60.0
		.0	100.0	
		.0	60.0	
COLUMN TOTAL		2	3	5
		40.0	60.0	100.0

PERCENTS AND TOTALS BASED ON RESPONDENTS

5 VALID CASES; 30 MISSING CASES

APPENDIX M

CNR Study Test Site Personnel Survey Responses

Fort Polk, Louisiana

Table 1

FORT POLK

CLINICAL NURSING RECORDS STUDY

TYPE OF RESPONDENT

VALUE LABEL	VALUE	FREQUENCY	PERCENT	VALID PERCENT	CUM PERCENT
RNS	1	60	41.7	41.7	41.7
PARA	2	57	39.6	39.6	81.3
WARD CLERK	3	8	5.6	5.6	86.8
PROFES- SIONAL	4	19	13.2	13.2	100.0
	TOTAL	144	100.0	100.0	

VALID CASES 144 MISSING CASES 0

Table 2

FORT POLK

CLINICAL NURSING RECORDS STUDY

"COMPARED TO THE OLD SYSTEM, I FEEL THE TEST FORMS SAVE ME NURSING DOCUMENTATION TIME" BY TYPE OF PROVIDER

A1 / COUNT	TYPE 1 RNS (1)	TYPE 1 PARA (2)	ROW TOTAL
1 STRONGLY AGREE	37	22	59
			54.1
2 AGREE	19	24	43
			39.4
3 DISAGREE	1	5	6
			5.5
4 STRONGLY DISAGRE	1		1
			.9
COLUMN TOTAL	58	51	109
	53.2	46.8	100.0

NUMBER OF MISSING OBSERVATIONS = 35

Table 3

FORT POLK

CLINICAL NURSING RECORDS STUDY

"COMPARED TO THE OLD SYSTEM, I FEEL THE TEST FORMS HELP AVOID WRITING SAME INFORMATION SEVERAL PLACES"

BY TYPE OF PROVIDER

A2	COUNT	TYPE: RNS (1)	PARA (2)	WARD CLERK (3)	ROW TOTAL
1 STRONGLY AGREE		35	24	4	63
					54.3
2 AGREE		20	24	4	48
					41.4
3 DISAGREE			2		2
					1.7
4 STRONGLY DISAGRE		3			3
					2.6
	COLUMN TOTAL	58	50	8	116
		50.0	43.1	6.9	100.0

NUMBER OF MISSING OBSERVATIONS = 28

Table 4

FORT POLK

CLINICAL NURSING RECORDS STUDY

"COMPARED TO THE OLD SYSTEM, I FEEL THE TEST FORMS IMPROVE COMMUNICATIONS ABOUT THE PATIENT AMONG NURSING PERSONNEL"

BY TYPE OF PROVIDER

A3	TYPE COUNT / RNS (1)	PARA (2)	ROW TOTAL
1 STRONGLY AGREE	14	8	22
			20.2
2 AGREE	34	36	70
			64.2
3 DISAGREE	9	5	14
			12.8
4 STRONGLY DISAGRE	1	2	3
			2.8
COLUMN TOTAL	58	51	109
	53.2	46.8	100.0

NUMBER OF MISSING OBSERVATIONS = 35

Table 5

FORT POLK

CLINICAL NURSING RECORDS STUDY

"COMPARED TO THE OLD SYSTEM, I FEEL THE TEST FORMS IMPROVE COMMUNICATIONS ABOUT THE PATIENT BETWEEN NURSING AND OTHER HEALTH CARE PROFESSIONALS"

BY TYPE OF PROVIDER

A4	TYPE		
COUNT	IRNS	PARA	ROW TOTAL
	1	2	
1 STRONGLY AGREE	16	7	23
			21.1
2 AGREE	30	28	58
			53.2
3 DISAGREE	9	14	23
			21.1
4 STRONGLY DISAGRE	3	2	5
			4.6
COLUMN TOTAL	58	51	109
	53.2	46.8	100.0

NUMBER OF MISSING OBSERVATIONS = 35

Table 6

FORT POLK

CLINICAL NURSING RECORDS STUDY

"COMPARED TO THE OLD SYSTEM, I FEEL THE TEST FORMS ENCOURAGE ME TO USE THE NURSING PROCESS"

BY TYPE OF PROVIDER

A5	COUNT	TYPE RNS	ROW TOTAL
STRONGLY AGREE	1	18	18 31.6
AGREE	2	32	32 56.1
DISAGREE	3	6	6 10.5
STRONGLY DISAGREE	4	1	1 1.8
	COLUMN TOTAL	57 100.0	57 100.0

NUMBER OF MISSING OBSERVATIONS = 87

Table 7

FORT POLK

CLINICAL NURSING RECORDS STUDY

"COMPARED TO THE OLD SYSTEM, I FEEL THE TEST FORMS

ARE EASIER TO USE"

BY TYPE OF PROVIDER

A6	COUNT	TYPE RNS 1	PARA 2	WARD CLERK 3	ROW TOTAL
1 STRONGLY AGREE		24	24	2	50 41.7
2 AGREE		30	24	6	60 50.0
3 DISAGREE		3	6		9 7.5
4 STRONGLY DISAGRE		1			1 .8
	COLUMN TOTAL	58 48.3	54 45.0	8 6.7	120 100.0

NUMBER OF MISSING OBSERVATIONS = 24

Table 8

FORT POLK

CLINICAL NURSING RECORDS STUDY

"COMPARED TO THE OLD SYSTEM, I FEEL THE TEST FORMS SHOULD HAVE BEEN A MORE DRASTIC CHANGE"

BY TYPE OF PROVIDER

A7	COUNT	TYPE IRNS (1)	PARA (2)	WARD CLERK (3)	ROW TOTAL
1 STRONGLY AGREE	1	1	1		2
					1.8
2 AGREE	2	5	10	4	19
					16.8
3 DISAGREE	3	40	37	4	81
					71.7
4 STRONGLY DISAGRE	4	9	2		11
					9.7
	COLUMN TOTAL	55	50	8	113
		48.7	44.2	7.1	100.0

NUMBER OF MISSING OBSERVATIONS = 31

Table 9

FORT POLK

CLINICAL NURSING RECORDS STUDY

"COMPARED TO THE OLD SYSTEM, I FEEL THE TEST FORMS

ARE A DEFINITE IMPROVEMENT"

BY TYPE OF PROVIDER

A8	COUNT	TYPE 1 IRNS 1	PARA 2	WARD CLERK 3	ROW TOTAL
STRONGLY AGREE	1	20	13	2	35
					29.2
AGREE	2	35	35	6	76
					63.3
DISAGREE	3	2	6		8
					6.7
STRONGLY DISAGRE	4	1			1
					.8
COLUMN TOTAL		58	54	8	120
		48.3	45.0	6.7	100.0

NUMBER OF MISSING OBSERVATIONS = 24

Table 10

FORT POLK

CLINICAL NURSING RECORDS STUDY

"COMPARED TO THE OLD SYSTEM, I FEEL THE TEST FORMS PROVIDE ME A BETTER PICTURE OF WHAT IS HAPPENING TO THE PATIENT"

BY TYPE OF PROVIDER

A9	COUNT	TYPE IRNS (1)	TYPE PARA (2)	ROW TOTAL
1 STRONGLY AGREE		9	9	18
				16.2
2 AGREE		38	34	72
				64.9
3 DISAGREE		9	9	18
				16.2
4 STRONGLY DISAGRE		1	2	3
				2.7
	COLUMN TOTAL	57	54	111
		51.4	48.6	100.0

NUMBER OF MISSING OBSERVATIONS = 33

Table 11

FORT POLK

CLINICAL NURSING RECORDS STUDY

"COMPARED TO THE OLD SYSTEM, I FEEL THE TEST FORMS REDUCE THE AMOUNT OF PAPERWORK I HAVE TO DO"

BY TYPE OF PROVIDER

A10 / COUNT	TYPE 1 IRNS	11 PARA	21 WARD CLERK	31	ROW TOTAL
1 STRONGLY AGREE	23	25	2		50
					42.0
2 AGREE	28	17	3		48
					40.3
3 DISAGREE	5	11	2		18
					15.1
4 STRONGLY DISAGREE	2	1			3
					2.5
COLUMN TOTAL	58	54	7		119
	48.7	45.4	5.9		100.0

NUMBER OF MISSING OBSERVATIONS = 25

Table 12

FORT POLK

CLINICAL NURSING RECORDS STUDY

"COMPARED TO THE OLD SYSTEM, I FEEL THE TEST FORMS HAVE IMPROVED THE QUALITY OF DOCUMENTATION ON MY NURSING UNIT"

BY TYPE OF PROVIDER

		TYPE		
	COUNT	IRNS	PARA	ROW TOTAL
		1	2	
All	1	11	15	26
	STRONGLY AGREE			23.6
	2	38	27	65
	AGREE			59.1
	3	6	6	12
	DISAGREE			10.9
	4	2	5	7
	STRONGLY DISAGRE			6.4
	COLUMN TOTAL	57	53	110
		51.8	48.2	100.0

NUMBER OF MISSING OBSERVATIONS = 34

Table 13

FORT POLK

CLINICAL NURSING RECORDS STUDY

"THE NUMBER OF NURSING HISTORY QUESTIONS IS ADEQUATE"

BY TYPE OF PROVIDER

B1	COUNT	TYPE IRNS (1)	PARA (2)	ROW TOTAL
1 STRONGLY AGREE	1	15	10	25
				24.0
AGREE	2	22	33	55
				52.9
DISAGREE	3	16	7	23
				22.1
STRONGLY DISAGRE	4	1		1
				1.0
	COLUMN TOTAL	54	50	104
		51.9	48.1	100.0

NUMBER OF MISSING OBSERVATIONS = 40

Table 14

FORT POLK

CLINICAL NURSING RECORDS STUDY

"THE CONTENT OF THE NURSING HISTORY QUESTIONS IS AS THOROUGH AS I NEED THEM TO BE"

BY TYPE OF PROVIDER

B2	COUNT	TYPE IRNS 1	PARA 11	PARA 21	ROW TOTAL
STRONGLY AGREE	1	10	8		18
					17.5
AGREE	2	23	32		55
					53.4
DISAGREE	3	20	8		28
					27.2
STRONGLY DISAGRE	4	1	1		2
					1.9
	COLUMN TOTAL	54	49		103
		52.4	47.6		100.0

NUMBER OF MISSING OBSERVATIONS = 41

Table 15

FORT POLK

CLINICAL NURSING RECORDS STUDY

"ON MY NURSING UNIT THE BLOCK FOR PATIENT'S PERSONAL ARTICLES AND VALUABLES IS HELPFUL"

BY TYPE OF PROVIDER

B3	COUNT	TYPE IRNS 1	PARA 11	WARD CLERK 21	31	ROW TOTAL
STRONGLY AGREE	1	10	7	1		18
						15.9
AGREE	2	24	28	4		56
						49.6
DISAGREE	3	15	13	2		30
						26.5
STRONGLY DISAGREE	4	6	3			9
						8.0
	COLUMN TOTAL	55	51	7		113
		48.7	45.1	6.2		100.0

NUMBER OF MISSING OBSERVATIONS = 31

Table 16

FORT POLK

CLINICAL NURSING RECORDS STUDY

"ON MY NURSING UNIT MOST NURSING HISTORIES ARE

DONE BY NON-RN/ANC PERSONNEL."

BY TYPE OF PROVIDER

B4	COUNT	TYPE IRNS 1	PARA 2	WARD CLERK 3	ROW TOTAL
1 STRONGLY AGREE		12	9	2	23
					20.2
2 AGREE		11	11	3	25
					21.9
3 DISAGREE		16	26	1	43
					37.7
4 STRONGLY DISAGRE		17	6		23
					20.2
	COLUMN TOTAL	56	52	6	114
		49.1	45.6	5.3	100.0

NUMBER OF MISSING OBSERVATIONS = 30

Table 17

FORT POLK

CLINICAL NURSING RECORDS STUDY

"ON MY NURSING UNIT ALL NURSING ASSESSMENTS ARE

DONE BY RNs AND ANCs"

BY TYPE OF PROVIDER

B5	COUNT	TYPE IRNS 1	PARA 2	WARD CLERK 3	ROW TOTAL
1		39	23	2	64
STRONGLY AGREE					54.2
2		14	14	4	32
AGREE					27.1
3		5	15	1	21
DISAGREE					17.8
4			1		1
STRONGLY DISAGRE					.8
	COLUMN TOTAL	58	53	7	118
		49.2	44.9	5.9	100.0

NUMBER OF MISSING OBSERVATIONS = 26

Table 18

FORT POLK

CLINICAL NURSING RECORDS STUDY

"ON MY NURSING UNIT AN OVERPRINT IS USED FOR THE ASSESSMENT"

BY TYPE OF PROVIDER

B6	COUNT	TYPE IRNS 11	ROW TOTAL
STRONGLY AGREE	1	10	10
			18.5
AGREE	2	8	8
			14.8
DISAGREE	3	20	20
			37.0
STRONGLY DISAGRE	4	16	16
			29.6
	COLUMN TOTAL	54	54
		100.0	100.0

NUMBER OF MISSING OBSERVATIONS = 90

Table 19

FORT POLK

CLINICAL NURSING RECORDS STUDY

"ON MY NURSING UNIT WE OFTEN USE THE HISTORY

AND ASSESSMENT CONTINUATION SHEET"

BY TYPE OF PROVIDER

B7	COUNT	TYPE IRNS 1	PARA 2	WARD CLERK 3	ROW TOTAL
STRONGLY AGREE	1	4	7		11
					9.8
AGREE	2	9	18	1	28
					25.0
DISAGREE	3	25	22	4	51
					45.5
STRONGLY DISAGREE	4	17	3	2	22
					19.6
	COLUMN TOTAL	55	50	7	112
		49.1	44.6	6.3	100.0

NUMBER OF MISSING OBSERVATIONS = 32

Table 20

FORT POLK

CLINIC NURSING RECORDS STUDY

"OVERPRINTING THE ASSESSMENT CATEGORIES FROM THE STANDARDS OF NURSING PRACTICE (DA PAM 40-5) IS HELPFUL TO ME"

BY TYPE OF PROVIDER

BB	COUNT / TYPE: IRNS	ROW TOTAL
1 STRONGLY AGREE	22	22
		43.1
2 AGREE	20	20
		39.2
3 DISAGREE	4	4
		7.8
4 STRONGLY DISAGRE	5	5
		9.8
COLUMN TOTAL	51	51
	100.0	100.0

NUMBER OF MISSING OBSERVATIONS = 93

Table 21

FORT POLK

CLINIC NURSING RECORDS STUDY

"OVERPRINTING THE ASSESSMENT CATEGORIES FROM THE STANDARDS OF NURSING PRACTICE (DA PAM 40-5) HAS INCREASED MY USE OF THE CATEGORIES"

BY TYPE OF PROVIDER

B9	COUNT	TYPE IRNS	ROW TOTAL
STRONGLY AGREE	1	18	18 35.3
AGREE	2	21	21 41.2
DISAGREE	3	7	7 13.7
STRONGLY DISAGREE	4	5	5 9.8
	COLUMN TOTAL	51 100.0	51 100.0

NUMBER OF MISSING OBSERVATIONS = 93

Table 22

FORT POLK

CLINIC NURSING RECORDS STUDY

"OVERPRINTING THE ASSESSMENT CATEGORIES FROM THE STANDARDS OF NURSING PRACTICE (DA PAM 40-5) SHOULD BE CONTINUED"

BY TYPE OF PROVIDER

B10	COUNT	TYPE RNS	ROW TOTAL
STRONGLY AGREE	1	25 50.0	25 50.0
AGREE	2	19 38.0	19 38.0
DISAGREE	3	1 2.0	1 2.0
STRONGLY DISAGREE	4	5 10.0	5 10.0
	COLUMN TOTAL	50 100.0	50 100.0

NUMBER OF MISSING OBSERVATIONS = 94

Table 23

FORT POLK

CLINICAL NURSING RECORDS STUDY

"I LIKE THE IDEA OF THE NURSING HISTORY AND ASSESSMENT, IF COMPLETED ON ADMISSION, SERVING AS THE ADMISSION NURSING NOTE"

BY TYPE OF PROVIDER

B11	COUNT	TYPE RNS	ROW TOTAL
		1	
STRONGLY AGREE	1	51 89.5	51 89.5
AGREE	2	6 10.5	6 10.5
	COLUMN TOTAL	57 100.0	57 100.0

NUMBER OF MISSING OBSERVATIONS = 87

Table 24

FORT POLK

CLINICAL NURSING RECORDS STUDY

"OVERPRINTING THE NURSING DIAGNOSES ONTO THE CARE PLAN

IS HELPFUL TO ME"

BY TYPE OF PROVIDER

B12	COUNT	TYPE 1 IRNS 1	1I	ROW TOTAL
STRONGLY AGREE	1	24		24
		44.4		44.4
AGREE	2	21		21
		38.9		38.9
DISAGREE	3	4		4
		7.4		7.4
STRONGLY DISAGRE	4	5		5
		9.3		9.3
	COLUMN TOTAL	54		54
		100.0		100.0

NUMBER OF MISSING OBSERVATIONS = 90

Table 25

FORT POLK

CLINICAL NURSING RECORDS STUDY

"OVERPRINTING THE NURSING DIAGNOSES ONTO THE CARE PLAN HAS INCREASED MY USE OF THE DIAGNOSES"

BY TYPE OF PROVIDER

B13	COUNT	TYPE IRNS 1	ROW TOTAL
STRONGLY AGREE	1	22	22 40.7
AGREE	2	20	20 37.0
DISAGREE	3	7	7 13.0
STRONGLY DISAGRE	4	5	5 9.3
	COLUMN TOTAL	54 100.0	54 100.0

NUMBER OF MISSING OBSERVATIONS = 90

Table 26

FORT POLK

CLINICAL NURSING RECORDS STUDY

"OVERPRINTING THE NURSING DIAGNOSES ONTO THE CARE PLAN SHOULD BE CONTINUED"

BY TYPE OF PROVIDER

B14	COUNT	TYPE IRNS 11	ROW TOTAL
STRONGLY AGREE	1	24	24
			43.6
AGREE	2	22	22
			40.0
DISAGREE	3	3	3
			5.5
STRONGLY DISAGRE	4	6	6
			10.9
	COLUMN TOTAL	55	55
		100.0	100.0

NUMBER OF MISSING OBSERVATIONS = 89

Table 27

FORT POLK

CLINICAL NURSING RECORDS STUDY

"I READ THE NURSING CARE PLAN TO LEARN THE OVERALL GOALS FOR THE PATIENT"

BY TYPE OF PROVIDER

B15	COUNT	TYPE PARA 21	ROW TOTAL
STRONGLY AGREE	1	10	10
			19.6
AGREE	2	32	32
			62.7
DISAGREE	3	7	7
			13.7
STRONGLY DISAGRE	4	2	2
			3.9
	COLUMN TOTAL	51 100.0	51 100.0

NUMBER OF MISSING OBSERVATIONS = 93

Table 28

FORT POLK

CLINICAL NURSING RECORDS STUDY

"OTHER THAN THE PATIENT IDENTIFICATION STAMP, I HAVE COMPLETED SOME PORTIONS OF THE NURSING DISCHARGE SUMMARY FOR THE NURSES"

BY TYPE OF PROVIDER

C1	COUNT	TYPE 1 PARA	2 WARD CLERK	3	ROW TOTAL
1 STRONGLY AGREE	1	13	2		15
					28.3
2 AGREE	2	16	2		18
					34.0
3 DISAGREE	3	14	1		15
					28.3
4 STRONGLY DISAGREE	4	4	1		5
					9.4
	COLUMN TOTAL	47	6		53
		88.7	11.3		100.0

NUMBER OF MISSING OBSERVATIONS = 91

Table 29

FORT POLK

CLINICAL NURSING RECORDS STUDY

"OTHER THAN THE PATIENT IDENTIFICATION STAMP, THE ENTIRE NURSING DISCHARGE SUMMARY IS COMPLETED ONLY BY AN RN/ANC ON MY NURSING UNIT"

BY TYPE OF PROVIDER

C2	COUNT / TYPE	PARA (21)	WARD CLERK (31)	ROW TOTAL
1		15		15
STRONGLY AGREE				25.4
2		15	2	17
AGREE				28.8
3		15	4	19
DISAGREE				32.2
4		8		8
STRONGLY DISAGRE				13.6
COLUMN TOTAL		53	6	59
		89.8	10.2	100.0

NUMBER OF MISSING OBSERVATIONS = 85

Table 30

FORT POLK

CLINICAL NURSING RECORDS STUDY

"NURSING DISCHARGE SUMMARY (DA FORM 3888-5 TEST) - ELEMENTS ON THE FORM ARE THOSE I WOULD INCLUDE IN A DISCHARGE NURSING NOTE"

BY TYPE OF PROVIDER

C3	COUNT	TYPE IRNS	ROW TOTAL
STRONGLY AGREE	1	24	24
			45.3
AGREE	2	27	27
			50.9
DISAGREE	3	2	2
			3.8
	COLUMN TOTAL	53	53
		100.0	100.0

NUMBER OF MISSING OBSERVATIONS = 91

Table 31

FORT POLK

CLINICAL NURSING RECORDS STUDY

"NURSING DISCHARGE SUMMARY (DA FORM 3888-5 TEST) - I LIKE TO HAVE THE DISCHARGE SUMMARY SERVE AS THE NURSING DISCHARGE NOTE"

BY TYPE OF PROVIDER

C4	COUNT	TYPE IRNS	ROW TOTAL
STRONGLY AGREE	1	33 60.0	33 60.0
AGREE	2	20 36.4	20 36.4
DISAGREE	3	2 3.6	2 3.6
	COLUMN TOTAL	55 100.0	55 100.0

NUMBER OF MISSING OBSERVATIONS = 89

Table 32

FORT POLK

CLINICAL NURSING RECORDS STUDY

"NURSING DISCHARGE SUMMARY (DA FORM 3888-5 TEST) -

IT IS HELPFUL TO HAVE A COPY FOR THE PATIENT"

BY TYPE OF PROVIDER

C5	COUNT	TYPE RNS	ROW TOTAL
		11	
	1	36	36
STRONGLY AGREE			65.5
	2	18	18
AGREE			32.7
	3	1	1
DISAGREE			1.8
	COLUMN TOTAL	55 100.0	55 100.0

NUMBER OF MISSING OBSERVATIONS = 89

Table 33

FORT POLK

CLINICAL NURSING RECORDS STUDY

"NURSING DISCHARGE SUMMARY (DA FORM 3888-5 TEST) - IT IS IMPORTANT FOR A NURSING SUMMARY TO APPEAR IN THE OUTPATIENT RECORD"

BY TYPE OF PROVIDER

C6	COUNT	TYPE IRNS 11	ROW TOTAL
1 STRONGLY AGREE	1	26	26
			48.1
2 AGREE	2	21	21
			38.9
3 DISAGREE	3	6	6
			11.1
4 STRONGLY DISAGRE	4	1	1
			1.9
	COLUMN TOTAL	54	54
		100.0	100.0

NUMBER OF MISSING OBSERVATIONS = 90

Table 34

FORT POLK

CLINICAL NURSING RECORDS STUDY

"NURSING DISCHARGE SUMMARY (DA FORM 3888-5 TEST) - THE NURSING DISCHARGE SUMMARY FORM NEEDS TO BE KEPT IN THE SYSTEM"

BY TYPE OF PROVIDER

C7	COUNT	TYPE IRNS 1	ROW TOTAL
STRONGLY AGREE	1	26	26
		49.1	49.1
AGREE	2	24	24
		45.3	45.3
DISAGREE	3	3	3
		5.7	5.7
	COLUMN TOTAL	53	53
		100.0	100.0

NUMBER OF MISSING OBSERVATIONS = 91

Table 35

FORT POLK

CLINICAL NURSING RECORDS STUDY

"NURSING DISCHARGE SUMMARY (DA FORM 3888-5 TEST) - DISCHARGE SUMMARIES SHOULD BE IN A MULTIDISCIPLINARY FORMAT SO PHYSICIANS AND OTHER HEALTH CARE PROVIDERS COULD MAKE APPROPRIATE NOTATIONS"

BY TYPE OF PROVIDER

C8	COUNT	TYPE RNS	ROW TOTAL
STRONGLY AGREE	1	24	24 43.6
AGREE	2	19	19 34.5
DISAGREE	3	10	10 18.2
STRONGLY DISAGRE	4	2	2 3.6
	COLUMN TOTAL	55 100.0	55 100.0

NUMBER OF MISSING OBSERVATIONS = 89

Table 36

FORT POLK

CINICAL NURSING RECORDS STUDY

"DOCTOR'S ORDERS MEDICATION/DOCTOR'S ORDERS NONMEDICATION

(DA FORM 4256-1 TEST; DA FORM 4256-2 TEST) -

WE FREQUENTLY USE THE BUFF COPY ON

NURSING UNIT"

BY TYPE OF PROVIDER

	TYPE			
COUNT	IRNS	PARA	WARD CLERK	ROW TOTAL
	1	2	3	
D1				
1 STRONGLY AGREE	11	5	1	17
				14.9
2 AGREE	18	20	4	42
				36.8
3 DISAGREE	16	20	2	38
				33.3
4 STRONGLY DISAGRE	12	4	1	17
				14.9
COLUMN TOTAL	57	49	8	114
	50.0	43.0	7.0	100.0

NUMBER OF MISSING OBSERVATIONS = 30

Table 37

FORT POLK

CINICAL NURSING RECORDS STUDY

"DOCTOR'S ORDERS MEDICATION/DOCTOR'S ORDERS NONMEDICATION

(DA FORM 4256-1 TEST; DA FORM 4256-2 TEST) - I LIKE

NOT HAVING TO RECOPY SOME SINGLE ACTION ORDERS

ONTO THE THERAPEUTIC DOCUMENTATION CARE

PLAN"

BY TYPE OF PROVIDER

D2	TYPE COUNT	IRNS 1	PARA 2	WARD CLERK 3	ROW TOTAL
1 STRONGLY AGREE		34	15	4	53 45.3
2 AGREE		9	33	4	46 39.3
3 DISAGREE		10	1		11 9.4
4 STRONGLY DISAGRE		3	4		7 6.0
	COLUMN TOTAL	56 47.9	53 45.3	8 6.8	117 100.0

NUMBER OF MISSING OBSERVATIONS = 27

Table 38

FORT POLK

CLINICAL NURSING RECORDS STUDY

"DURING THE TEST PERIOD, HOW OFTEN DID YOU USE THE NURSING HISTORY AND ASSESSMENT TO LEARN ABOUT NURSING ACTIVITIES AND THE PATIENT'S CONDITION?"

BY TYPE OF PROVIDER

X1A	COUNT	TYPE: PROFESSIONAL (41)	ROW TOTAL
EVERY PNT	1	5	5 26.3
MOST PNTS	2	5	5 26.3
RARELY	3	8	8 42.1
NEVER	4	1	1 5.3
	COLUMN TOTAL	19 100.0	19 100.0

NUMBER OF MISSING OBSERVATIONS = 125

Table 39

FORT POLK

CLINICAL NURSING RECORDS STUDY

"DURING THE TEST PERIOD, HOW OFTEN DID YOU USE THE NURSING CARE PLAN TO LEARN ABOUT NURSING ACTIVITY AND THE PATIENT'S CONDITION?"

BY TYPE OF PROVIDER

X1B	COUNT / TYPE	PROFESSIONAL (4)	ROW TOTAL
EVERY PNT	1	3	3
			15.8
MOST PNTS	2	1	1
			5.3
RARELY	3	10	10
			52.6
NEVER	4	5	5
			26.3
	COLUMN TOTAL	19	19
		100.0	100.0

NUMBER OF MISSING OBSERVATIONS = 125

Table 40

FORT POLK

CLINICAL NURSING RECORDS STUDY

"DURING THE TEST PERIOD, HOW OFTEN DID YOU USE THE NURSING DISCHARGE SUMMARY TO LEARN ABOUT NURSING ACTIVITIES AND THE PATIENT'S CONDITION?"

BY TYPE OF PROVIDER

X1C	COUNT / TYPE: PROFESSIONAL (4)	ROW TOTAL
1 EVERY PNT	1	1
	5.3	5.3
2 MOST PNTS	1	1
	5.3	5.3
3 RARELY	12	12
	63.2	63.2
4 NEVER	5	5
	26.3	26.3
COLUMN TOTAL	19	19
	100.0	100.0

NUMBER OF MISSING OBSERVATIONS = 125

Table 41

FORT POLK

CLINICAL NURSING RECORDS STUDY

"DURING THE TEST PERIOD, HOW OFTEN DID YOU USE THE THERAPEUTIC DOCUMENTATION CARE PLAN, NONMEDICATION?"

BY TYPE OF PROVIDER

X1D	COUNT / TYPE	PROFESSIONAL (41)	ROW TOTAL
EVERY PNT	1	5	5
			26.3
MOST PNTS	2	3	3
			15.8
RARELY	3	7	7
			36.8
NEVER	4	4	4
			21.1
	COLUMN TOTAL	19	19
		100.0	100.0

NUMBER OF MISSING OBSERVATIONS = 125

Table 42

FORT POLK

CLINICAL NURSING RECORDS STUDY

"DURING THE TEST PERIOD, HOW OFTEN DID YOU USE THE THERAPEUTIC DOCUMENTATION CARE PLAN, MEDICATION?"

BY TYPE OF PROVIDER

XIE	COUNT	TYPE PROFESSIONAL 41	ROW TOTAL
EVERY PNT	1	5 26.3	5 26.3
MOST PNTS	2	2 10.5	2 10.5
RARELY	3	8 42.1	8 42.1
NEVER	4	4 21.1	4 21.1
	COLUMN TOTAL	19 100.0	19 100.0

NUMBER OF MISSING OBSERVATIONS = 125

Table 43

FORT POLK

CLINICAL NURSING RECORDS STUDY

"DURING THE TEST PERIOD, HOW OFTEN DID YOU USE THE TPR GRAPHIC?"

BY TYPE OF PROVIDER

		TYPE	
	COUNT	PROFESSIONAL	RDN TOTAL
		4	
X1F			
1 EVERY PNT	1	17	17
			89.5
2 MOST PNTS	2	2	2
			10.5
	COLUMN TOTAL	19	19
		100.0	100.0

NUMBER OF MISSING OBSERVATIONS = 125

Table 44

FORT POLK

CLINICAL NURSING RECORDS STUDY

"DURING THE TEST PERIOD, HOW OFTEN DID YOU USE THE PROGRESS NOTES?"

BY TYPE OF PROVIDER

X1G	COUNT / ROW PCT	TYPE: PROFESSIONAL (4)	ROW TOTAL
EVERY PNT	1	11	11 / 57.9
MOST PNTS	2	4	4 / 21.1
RARELY	3	3	3 / 15.8
NEVER	4	1	1 / 5.3
	COLUMN TOTAL	19 / 100.0	19 / 100.0

NUMBER OF MISSING OBSERVATIONS = 125

Table 45

FORT POLK

CLINICAL NURSING RECORDS STUDY

"DURING THE TEST PERIOD, HOW OFTEN DID YOU USE THE OTHER FORMS TO REVIEW NURSING CARE?"

BY TYPE OF PROVIDER

	TYPE	
COUNT	PROFES-SIONAL	ROW TOTAL
X1H	41	
1 EVERY PNT	2	2 100.0
COLUMN TOTAL	2 100.0	2 100.0

NUMBER OF MISSING OBSERVATIONS = 142

Table 46

FORT POLK

CLINICAL NURSING RECORDS STUDY

"PRIOR TO THE TEST PERIOD, HOW OFTEN HAD YOU USED THE NURSING HISTORY AND ASSESSMENT TO LEARN ABOUT NURSING ACTIVITIES AND THE PATIENT'S CONDITION?"

BY TYPE OF PROVIDER

X3A	COUNT	TYPE PROFESSIONAL 41	ROW TOTAL
EVERY PNT	1	4 22.2	4 22.2
MOST PNTS	2	5 27.8	5 27.8
RARELY	3	9 50.0	9 50.0
	COLUMN TOTAL	18 100.0	18 100.0

NUMBER OF MISSING OBSERVATIONS = 126

Table 47

FORT POLK

CLINICAL NURSING RECORDS STUDY

"PRIOR TO THE TEST PERIOD, HOW OFTEN HAD YOU USED THE NURSING CARE PLAN TO LEARN ABOUT NURSING ACTIVITIES AND THE PATIENT'S CONDITION?"

BY TYPE OF PROVIDER

X3B	COUNT	TYPE PROFESSIONAL	ROW TOTAL
EVERY PNT	1	3	3
			16.7
MOST PNTS	2	2	2
			11.1
RARELY	3	9	9
			50.0
NEVER	4	4	4
			22.2
COLUMN TOTAL		18	18
		100.0	100.0

NUMBER OF MISSING OBSERVATIONS = 126

Table 48

FORT POLK

CLINICAL NURSING RECORDS STUDY

"PRIOR TO THE TEST PERIOD, HOW OFTEN HAD YOU USED THE NURSING DISCHARGE SUMMARY TO LEARN ABOUT NURSING ACTIVITIES AND THE PATIENT'S CONDITION?"

BY TYPE OF PROVIDER

X3C	COUNT / ROW TOTAL	TYPE: PROFESSIONAL (41)
MOST PNTS	2	1
	ROW TOTAL	5.6
RARELY	3	13
	ROW TOTAL	72.2
NEVER	4	4
	ROW TOTAL	22.2
COLUMN TOTAL		18
		100.0
	ROW TOTAL	18
		100.0

NUMBER OF MISSING OBSERVATIONS = 126

Table 49

FORT POLK

CLINICAL NURSING RECORDS STUDY

"PRIOR TO THE TEST PERIOD, HOW OFTEN HAD YOU USED THE THERAPEUTIC DOCUMENTATION CARE PLAN, NONMEDICATION?"

BY TYPE OF PROVIDER

X3D	COUNT	TYPE: PROFESSIONAL (4)	ROW TOTAL
EVERY PNT	1	3	3
			16.7
MOST PATS	2	3	3
			16.7
RARELY	3	10	10
			55.6
NEVER	4	2	2
			11.1
	COLUMN TOTAL	18	18
		100.0	100.0

NUMBER OF MISSING OBSERVATIONS = 126

Table 50

FORT POLK

CLINICAL NURSING RECORDS STUDY

"PRIOR TO THE TEST PERIOD, HOW OFTEN HAD YOU USED THE THERAPEUTIC DOCUMENTATION CARE PLAN, MEDICATION?"

BY TYPE OF PROVIDER

X3E	COUNT	TYPE: PROFESSIONAL (4)	ROW TOTAL
EVERY PNT	1	3	3
			16.7
MOST PATS	2	4	4
			22.2
RARELY	3	9	9
			50.0
NEVER	4	2	2
			11.1
	COLUMN TOTAL	18	18
		100.0	100.0

NUMBER OF MISSING OBSERVATIONS = 126

Table 51

FORT POLK

CLINICAL NURSING RECORDS STUDY

"PRIOR TO THE TEST PERIOD, HOW OFTEN HAD YOU USED THE TPR GRAPHIC?"

BY TYPE OF PROVIDER

		TYPE	
	COUNT	PROFESSIONAL	ROW TOTAL
X3F		41	
EVERY PNT	1	17	17
			94.4
RARELY	3	1	1
			5.6
	COLUMN TOTAL	18	18
		100.0	100.0

NUMBER OF MISSING OBSERVATIONS = 126

Table 52

FORT POLK

CLINICAL NURSING RECORDS STUDY

"PRIOR TO THE TEST PERIOD, HOW OFTEN HAD YOU USED THE NURSING NOTES?"

BY TYPE OF PROVIDER

X36	COUNT	TYPE PROFESSIONAL 4	ROW TOTAL
1 EVERY PNT	1	7 38.9	7 38.9
2 MOST PNTS	2	7 38.9	7 38.9
3 RARELY	3	4 22.2	4 22.2
	COLUMN TOTAL	18 100.0	18 100.0

NUMBER OF MISSING OBSERVATIONS = 126

Table 53

FORT POLK

CLINICAL NURSING RECORDS STUDY

"PRIOR TO THE TEST PERIOD, HOW OFTEN DID YOU USE OTHER FORMS TO REVIEW NURSING CARE?"

BY TYPE OF PROVIDER

		TYPE	
	COUNT	PROFESSIONAL	ROW TOTAL
		41	
X3H			
1	2	2	2
EVERY PNT			100.0
	COLUMN	2	2
	TOTAL	100.0	100.0

NUMBER OF MISSING OBSERVATIONS = 142

Table 54

FORT POLK

CLINICAL NURSING RECORDS STUDY

"DOCTOR'S ORDERS MEDICATION/DOCTOR'S ORDERS NONMEDICATION

(DA FORM 4256-1 TEST; DA FORM 4256-2 TEST) - HAVING

TWO SEPARATE ORDER SHEETS CAUSED MINIMAL

DIFFICULTIES FOR ME"

BY TYPE OF PROVIDER

D3	COUNT	TYPE IRNS 1	PARA 2	WARD CLERK 3	PROFES-SIONAL 4	ROW TOTAL
1 STRONGLY AGREE		21	13	2	1	37
						27.2
2 AGREE		26	33	4	8	71
						52.2
3 DISAGREE		6	4	2	5	17
						12.5
4 STRONGLY DISAGRE		6	2		3	11
						8.1
	COLUMN TOTAL	59	52	8	17	136
		43.4	38.2	5.9	12.5	100.0

NUMBER OF MISSING OBSERVATIONS = 8

Table 55

FORT POLK

CLINICAL NURSING RECORDS STUDY

"DOCTOR'S ORDERS MEDICATION/DOCTOR'S ORDERS NONMEDICATION (DA FORM 4256-1 TEST; DA FORM 4256-2 TEST) - ORDERS SHOULD CONTINUE TO REMAIN SEPARATED ON COLOR CODED MEDICATION AND NONMEDICATION SHEETS"

BY TYPE OF PROVIDER

D4	COUNT / TYPE	IRNS 1	PARA 2	WARD CLERK 3	PROFESSIONAL 4	ROW TOTAL
STRONGLY AGREE	1	28	29	3	1	60
						44.1
AGREE	2	18	22	4	6	50
						36.8
DISAGREE	3	6	3	1	5	15
						11.0
STRONGLY DISAGRE	4	6			5	11
						8.1
COLUMN TOTAL		58	53	8	17	136
		42.6	39.0	5.9	12.5	100.0

NUMBER OF MISSING OBSERVATIONS = 8

Table 56

FORT POLK

CLINICAL NURSING RECORDS STUDY

"DOCTOR'S ORDERS MEDICATION/DOCTOR'S ORDERS NONMEDICATION (DA FORM 4256-1 TEST; DA FORM 4256-2 TEST) - PRIOR TO THE TEST PERIOD, IF UNFAMILIAR WITH A PATIENT, I MOST OFTEN DETERMINED CURRENT MEDICATION(S) BY . . ."

BY TYPE OF PROVIDER

D6	COUNT / TYPE	PROFESSIONAL (41)	ROW TOTAL
REVIEW ALL OR OR	1	7	7
			43.8
REVIEW TO-MED	2	6	6
			37.5
ASK NURSE	3	3	3
			18.8
	COLUMN TOTAL	16	16
		100.0	100.0

NUMBER OF MISSING OBSERVATIONS = 128

Table 57

FORT POLK

CLINICAL NURSING RECORDS STUDY

"DOCTOR'S ORDERS MEDICATION/DOCTOR'S ORDERS NONMEDICATION

(DA FORM 4256-1 TEST; DA FORM 4256-2 TEST) -

DURING THE TEST PERIOD, AFTER THE SEPARATION OF ORDERS,

IF UNFAMILIAR WITH A PATIENT, I MOST OFTEN DETERMINED

CURRENT MEDICATION(S) BY . . ."

BY TYPE OF PROVIDER

D7	COUNT	TYPE 4	ROW TOTAL
REVIEW ALL DR OR	1	9	9
			56.3
REVIEW TO-MED	2	5	5
			31.3
ASK NURSE	3	2	2
			12.5
	COLUMN TOTAL	16	16
		100.0	100.0

NUMBER OF MISSING OBSERVATIONS = 128

Table 58

FORT POLK

CLINICAL NURSING RECORDS STUDY

"DOCTOR'S ORDERS MEDICATION/DOCTOR'S ORDERS NONMEDICATION

(DA FORM 4256-1 TEST; DA FORM 4256-2 TEST) -

IF WE WENT BACK TO THE 'OLD' ORDER SHEETS, I WOULD

HAVE NO DIFFICULTY IDENTIFYING COMPLETED SINGLE

ACTION ORDERS"

BY TYPE OF PROVIDER

DE	TYPE 1 RNS	2 PARA	3 WARD CLERK	ROW TOTAL
1 STRONGLY AGREE	11	1	2	14
				12.1
2 AGREE	23	25	4	52
				44.8
3 DISAGREE	18	19	2	39
				33.6
4 STRONGLY DISAGREE	5	6		11
				9.5
COLUMN TOTAL	57	51	8	116
	49.1	44.0	6.9	100.0

NUMBER OF MISSING OBSERVATIONS = 28

Table 59

FORT POLK

CLINICAL NURSING RECORDS STUDY

"DOCTOR'S ORDERS MEDICATION/DOCTOR'S ORDERS NONMEDICATION

(DA FORM 4256-1 TEST; DA FORM 4256-2 TEST) -

IF WE WENT BACK TO THE 'OLD' ORDER SHEETS, I WOULD STILL

WANT A COLUMN FOR SINGLE ACTION ORDERS TO PRECLUDE

MY HAVING TO RECOPY THEM ONTO THE THERAPEUTIC

DOCUMENTATION CARE PLANS"

BY TYPE OF PROVIDER

D9	COUNT	TYPE IRNS (1)	PARA (2)	WARD CLERK (3)	ROW TOTAL
STRONGLY AGREE	1	33	15	3	51
					44.7
AGREE	2	12	27	5	44
					38.6
DISAGREE	3	10	4		14
					12.3
STRONGLY DISAGRE	4	2	3		5
					4.4
	COLUMN TOTAL	57	49	8	114
		50.0	43.0	7.0	100.0

NUMBER OF MISSING OBSERVATIONS = 30

Table 60

FORT POLK

CLINICAL NURSING RECORDS STUDY

I LIKE BEING ABLE TO DOCUMENT (WITH EFFECTIVENESS CODES OR KEY WORDS) THE PATIENT'S RESPONSE DIRECTLY ON THE THERAPEUTIC DOCUMENTATION CARE PLANS"

BY TYPE OF PROVIDER

E1	COUNT \ TYPE	IRNS (1)	PARA (2)	ROW TOTAL
1 STRONGLY AGREE		41	16	57
		53.8		
2 AGREE		15	29	44
		41.5		
3 DISAGREE		1	4	5
		4.7		
	COLUMN TOTAL	57	49	106
		53.8	46.2	100.0

NUMBER OF MISSING OBSERVATIONS = 38

Table 61

FORT POLK

CLINICAL NURSING RECORDS STUDY

"MOST OF MY DOCUMENTATION IS RECORDED ON THE THERAPEUTIC DOCUMENTATION CARE PLANS"

BY TYPE OF PROVIDER

E2	COUNT	TYPE PARA 21	ROW TOTAL
STRONGLY AGREE	1	11	11
			22.9
AGREE	2	25	25
			52.1
DISAGREE	3	11	11
			22.9
STRONGLY DISAGRE	4	1	1
			2.1
	COLUMN TOTAL	48	48
		100.0	100.0

NUMBER OF MISSING OBSERVATIONS = 96

Table 62

FORT POLK

CLINICAL NURSING RECORDS STUDY

"IN THE PAST, I USED TO DO MOST OF MY DOCUMENTING ON THE NURSING NOTES (SF 510)"

BY TYPE OF PROVIDER

E3	COUNT	TYPE PARA (2)	ROW TOTAL
1 STRONGLY AGREE		16	16
			32.0
2 AGREE		33	33
			66.0
4 STRONGLY DISAGRE		1	1
			2.0
	COLUMN TOTAL	50	50
		100.0	100.0

NUMBER OF MISSING OBSERVATIONS = 94

Table 63

FORT POLK

CLINICAL NURSING RECORDS STUDY

"RECORDING THE PATIENT'S RESPONSE ON THE TD CARE PLAN IMPROVES MY DOCUMENTATION OF PATIENT CARE"

BY TYPE OF PROVIDER

E4	COUNT	TYPE 1 RNS	11 PARA	21	ROW TOTAL
1 STRONGLY AGREE		24	9		33
					31.1
2 AGREE		25	29		54
					50.9
3 DISAGREE		7	10		17
					16.0
4 STRONGLY DISAGRE		1	1		2
					1.9
	COLUMN TOTAL	57	49		106
		53.8	46.2		100.0

NUMBER OF MISSING OBSERVATIONS = 38

Table 64

FORT POLK

CLINICAL NURSING RECORDS STUDY

"RECORDING THE PATIENT'S RESPONSE ON THE THERAPEUTIC DOCUMENTATION CARE PLAN ENCOURAGES ME TO WRITE MORE NURSING ORDERS TO DESCRIBE NURSING ACTIVITIES WITH THE PATIENT"

BY TYPE OF PROVIDER

E5	COUNT	TYPE IRNS 11	ROW TOTAL
STRONGLY AGREE	1	27	27
		50.0	50.0
AGREE	2	18	18
		33.3	33.3
DISAGREE	3	8	8
		14.8	14.8
STRONGLY DISAGREE	4	1	1
		1.9	1.9
	COLUMN TOTAL	54	54
		100.0	100.0

NUMBER OF MISSING OBSERVATIONS = 90

Table 65

FORT POLK

CLINICAL NURSING RECORDS STUDY

"RECORDING THE PATIENT'S RESPONSE ON THE THERAPEUTIC DOCUMENTATION CARE PLAN IMPROVES COMMUNICATION AMONG NURSING PERSONNEL"

BY TYPE OF PROVIDER

E6	COUNT	TYPE 1 IRNS	TYPE 2 PARA	ROW TOTAL
1 STRONGLY AGREE	1	23	9	32
				29.9
2 AGREE	2	29	31	60
				56.1
3 DISAGREE	3	4	10	14
				13.1
4 STRONGLY DISAGRE	4		1	1
				.9
	COLUMN TOTAL	56	51	107
		52.3	47.7	100.0

NUMBER OF MISSING OBSERVATIONS = 37

Table 66

FORT POLK

CLINICAL NURSING RECORDS STUDY

"RECORDING THE PATIENT'S RESPONSE ON THE THERAPEUTIC DOCUMENTATION CARE PLAN IMPROVES COMMUNICATION BETWEEN NURSES AND OTHER HEALTH CARE PROVIDERS"

BY TYPE OF PROVIDER

E7	TYPE COUNT	RNS 1	PARA 2	ROW TOTAL
1 STRONGLY AGREE	1	12	9	21 19.4
2 AGREE	2	25	29	54 50.0
3 DISAGREE	3	18	12	30 27.8
4 STRONGLY DISAGRE	4	2	1	3 2.8
	COLUMN TOTAL	57 52.8	51 47.2	108 100.0

NUMBER OF MISSING OBSERVATIONS = 36

Table 67

FORT POLK

CLINICAL NURSING RECORDS STUDY

"RECORDING THE PATIENT'S RESPONSE ON THE TD CARE PLAN HAS DECREASED FRAGMENTED DOCUMENTATION IN THE RECORD"

BY TYPE OF PROVIDER

EB	COUNT	TYPE IRNS 1	PARA 1	PARA 2	ROW TOTAL
STRONGLY AGREE	1	17	10		27
					25.7
AGREE	2	32	30		62
					59.0
DISAGREE	3	6	10		16
					15.2
	COLUMN TOTAL	55	50		105
		52.4	47.6		100.0

NUMBER OF MISSING OBSERVATIONS = 39

Table 68

FORT POLK

CLINICAL NURSING RECORDS STUDY

"RECORDING THE PATIENT'S RESPONSE ON THE TD CARE PLAN

ALLOWS ME TO GIVE A MORE THOROUGH REPORT"

BY TYPE OF PROVIDER

E9	COUNT	TYPE RNS	ROW TOTAL
STRONGLY AGREE	1	20	20 35.7
AGREE	2	27	27 48.2
DISAGREE	3	8	8 14.3
STRONGLY DISAGREE	4	1	1 1.8
	COLUMN TOTAL	56 100.0	56 100.0

NUMBER OF MISSING OBSERVATIONS = 88

Table 69

FORT POLK

CLINICAL NURSING RECORDS STUDY

"RECORDING THE PATIENT'S RESPONSE ON THE TD CARE PLAN GIVES ME A BETTER 'PICTURE' OF WHAT HAPPENED TO THE PATIENT"

BY TYPE OF PROVIDER

	TYPE		
COUNT	IRNS	PARA	ROW TOTAL
	1	2	
E10			
1 STRONGLY AGREE	17	7	24
			22.4
2 AGREE	31	32	63
			58.9
3 DISAGREE	7	12	19
			17.8
4 STRONGLY DISAGREE	1		1
			.9
COLUMN TOTAL	56	51	107
	52.3	47.7	100.0

NUMBER OF MISSING OBSERVATIONS = 37

Table 70

FORT POLK

CLINICAL NURSING RECORDS STUDY

"I DID NOT DOCUMENT PATIENT RESPONSES ON THE THERAPUETIC DOCUMENTATION CARE PLANS"

BY TYPE OF PROVIDER

E11	COUNT / TYPE	IRNS (11)	PARA (21)	ROW TOTAL
STRONGLY AGREE	1	1		1
				1.0
AGREE	2	9	14	23
				22.3
DISAGREE	3	26	31	57
				55.3
STRONGLY DISAGRE	4	17	5	22
				21.4
	COLUMN TOTAL	53	50	103
		51.5	48.5	100.0

NUMBER OF MISSING OBSERVATIONS = 41

Table 71

FORT POLK

CLINICAL NURSING RECORDS STUDY

"I HAD MINIMAL DIFFICULTY RECORDING THE PATIENT'S RESPONSES ON THE THERAPEUTIC DOCUMENTATION CARE PLAN"

BY TYPE OF PROVIDER

E12	COUNT	TYPE 1 IRNS	PARA 11	PARA 21	ROW TOTAL
1 STRONGLY AGREE		15	5		20
					19.8
2 AGREE		32	32		64
					63.4
3 DISAGREE		7	8		15
					14.9
4 STRONGLY DISAGRE			2		2
					2.0
	COLUMN TOTAL	54	47		101
		53.5	46.5		100.0

NUMBER OF MISSING OBSERVATIONS = 43

Table 72

FORT POLK

CLINICAL NURSING RECORDS STUDY

"THE EXPANDED USE OF THE THERAPEUTIC DOCUMENTATION CARE PLAN (BEING ABLE TO DOCUMENT RESPONSES) IS A CONCEPT WHICH SHOULD BE AVAILABLE TO ALL NURSING PERSONNEL WORLDWIDE"

BY TYPE OF PROVIDER

E13	COUNT	TYPE: IRNS (1)	TYPE: PARA (2)	ROW TOTAL
STRONGLY AGREE	1	29	7	36
		34.6		
AGREE	2	24	39	63
		60.6		
DISAGREE	3	2	2	4
		3.8		
STRONGLY DISAGRE	4		1	1
			1.0	
	COLUMN TOTAL	55	49	104
		52.9	47.1	100.0

NUMBER OF MISSING OBSERVATIONS = 40

Table 73

FORT POLK

CLINICAL NURSING RECORDS STUDY

"THE 'FOLDER' TYPE FORMAT OF THE THERAPEUTIC DOCUMENTATION CARE PLANS IS AN IMPROVEMENT"

BY TYPE OF PROVIDER

E14	COUNT	TYPE IRNS 11	PARA 21	WARD CLERK 31	ROW TOTAL
1 STRONGLY AGREE		16	14	3	33
					28.2
2 AGREE		27	30	5	62
					53.0
3 DISAGREE		10	7		17
					14.5
4 STRONGLY DISAGREE		2	3		5
					4.3
	COLUMN TOTAL	55	54	8	117
		47.0	46.2	6.8	100.0

NUMBER OF MISSING OBSERVATIONS = 27

Table 74

FORT POLK

CLINICAL NURSING RECORDS STUDY

"THE 'FOLDER' TYPE FORMAT OF THE THERAPEUTIC DOCUMENTATION CARE PLANS SHOULD BE KEPT EVEN IF IT CANNOT BE OVERPRINTED WITH ORDERS"

BY TYPE OF PROVIDER

E15	TYPE 1 IRNS	PARA 2	WARD CLERK 3	ROW TOTAL
1 STRONGLY AGREE	14	8	1	23
				20.2
2 AGREE	24	28	5	57
				50.0
3 DISAGREE	14	13	1	28
				24.6
4 STRONGLY DISAGRE	2	4		6
				5.3
COLUMN TOTAL	54	53	7	114
	47.4	46.5	6.1	100.0

NUMBER OF MISSING OBSERVATIONS = 30

Table 75

FORT POLK

CLINICAL NURSING RECORDS STUDY

"THE 'FOLDER' TYPE FORMAT OF THE THERAPEUTIC DOCUMENTATION CARE PLANS SHOULD HAVE THE PATIENT IDENTIFICATION BLOCK PRINTED ON ALL PAGES"

BY TYPE OF PROVIDER

E16	COUNT	TYPE IRNS 1	PARA 2	WARD CLERK 3	ROW TOTAL
1 STRONGLY AGREE		11	6	1	18
					15.0
2 AGREE		19	22	3	44
					36.7
3 DISAGREE		22	23	3	48
					40.0
4 STRONGLY DISAGRE		5	4	1	10
					8.3
	COLUMN TOTAL	57	55	8	120
		47.5	45.8	6.7	100.0

NUMBER OF MISSING OBSERVATIONS = 24

Table 76

FORT POLK

CLINICAL NURSING RECORDS STUDY

"I LIKE THE STURDIER PAPER ON WHICH THE FORMS ARE PRINTED"

BY TYPE OF PROVIDER

E17	COUNT	TYPE 1 RNS	PARA	WARD CLERK	ROW TOTAL
		1	2	3	
1 STRONGLY AGREE	1	27	20	2	49
					41.5
2 AGREE	2	25	30	6	61
					51.7
3 DISAGREE	3	4	4		8
					6.8
	COLUMN TOTAL	56	54	8	118
		47.5	45.8	6.8	100.0

NUMBER OF MISSING OBSERVATIONS = 26

Table 77

FORT POLK

CLINICAL NURSING RECORDS STUDY

"HAVING SEPARATE PAGES FOR RECURRING, DELAYED, OR PRN ACTION ORDERS IS HELPFUL TO ME"

BY TYPE OF PROVIDER

E18	COUNT	TYPE 1 IRNS	PARA	WARD CLERK	ROW TOTAL
		1	2	3	
1 STRONGLY AGREE	1	24	14	5	43
					37.4
2 AGREE	2	28	32	3	63
					54.8
3 DISAGREE	3	4	4		8
					7.0
4 STRONGLY DISAGREE	4		1		1
					.9
	COLUMN TOTAL	56	51	8	115
		48.7	44.3	7.0	100.0

NUMBER OF MISSING OBSERVATIONS = 29

Table 78

FORT POLK

CLINICAL NURSING RECORDS STUDY

"TO MY KNOWLEDGE, THERE WERE NO TREATMENT OR MEDICATION ERRORS COMMITTED ON MY NURSING UNIT WHICH COULD BE BLAMED ON THE NEW FORMAT OF THE THERAPEUTIC DOCUMENTATION CARE PLANS"

BY TYPE OF PROVIDER

E19	COUNT	TYPE IRNS (1)	TYPE PARA (2)	ROW TOTAL
STRONGLY AGREE	1	18	13	31
				29.5
AGREE	2	20	29	49
				46.7
DISAGREE	3	13	5	18
				17.1
STRONGLY DISAGRE	4	4	3	7
				6.7
	COLUMN TOTAL	55	50	105
		52.4	47.6	100.0

NUMBER OF MISSING OBSERVATIONS = 39

Table 79

FORT POLK

CLINICAL NURSING RECORDS STUDY

"I WOULD PREFER TO HAVE THE THERAPEUTIC DOCUMENTATION CARE PLANS IN A SINGLE SHEET FORMAT (LIKE THE 'OLD' TDs) EVEN KNOWING THAT I WOULD HAVE LESS ROOM FOR DOCUMENTATION"

BY TYPE OF PROVIDER

E20	TYPE IRNS 1	PARA 2	WARD CLERK 3	ROW TOTAL
1 STRONGLY AGREE	3	4		7
				6.3
2 AGREE	9	10	2	21
				18.8
3 DISAGREE	28	28	5	61
				54.5
4 STRONGLY DISAGRE	14	9		23
				20.5
COLUMN TOTAL	54	51	7	112
	48.2	45.5	6.3	100.0

NUMBER OF MISSING OBSERVATIONS = 32

Table 80

FORT POLK

CLINICAL NURSING RECORDS STUDY

"IF A SINGLE SHEET FORMAT WERE TO BE USED, I WOULD PREFER A MEDIUM WEIGHT PAPER (LESS BULKY THAN THE TESTED PAPER)"

BY TYPE OF PROVIDER

E21	TYPE COUNT IRNS 1	PARA 2	WARD CLERK 3	ROW TOTAL
1 STRONGLY AGREE	2	1	2	5
				4.5
2 AGREE	10	15	2	27
				24.1
3 DISAGREE	34	27	3	64
				57.1
4 STRONGLY DISAGRE	8	7	1	16
				14.3
COLUMN TOTAL	54	50	8	112
	48.2	44.6	7.1	100.0

NUMBER OF MISSING OBSERVATIONS = 32

Table 81

FORT POLK

CLINICAL NURSING RECORDS STUDY

"ALL MEDICATION AND NONMEDICATION FORMS SHOULD

REMAIN COLOR CODED"

BY TYPE OF PROVIDER

E22	TYPE			
COUNT	IRNS	PARA	WARD CLERK	ROW TOTAL
	1	2	3	
1 STRONGLY AGREE	33	29	5	67
				56.8
2 AGREE	21	25	3	49
				41.5
3 DISAGREE	2			2
				1.7
COLUMN TOTAL	56	54	8	118
	47.5	45.8	6.8	100.0

NUMBER OF MISSING OBSERVATIONS = 26

Table 82

FORT POLK

CLINICAL NURSING RECORDS STUDY

"YELLOW HIGHLIGHTER USE SHOULD BE REINSTATED TO DISCONTINUE ORDERS"

BY TYPE OF PROVIDER

E23	TYPE IRNS (1)	PARA (2)	WARD CLERK (3)	ROW TOTAL
1 STRONGLY AGREE	36	24	4	64
				54.2
2 AGREE	10	16	2	28
				23.7
3 DISAGREE	6	7	2	15
				12.7
4 STRONGLY DISAGRE	4	7		11
				9.3
COLUMN TOTAL	56	54	8	118
	47.5	45.8	6.8	100.0

NUMBER OF MISSING OBSERVATIONS = 26

Table 83

FORT POLK

CLINICAL NURSING RECORDS STUDY

"THE INTEGRATED PROGRESS NOTE IMPROVES COMMUNICATIONS CONCERNING THE PATIENT AMONG ALL HEALTH CARE PROVIDERS"

BY TYPE OF PROVIDER

F1	TYPE 1 IRNS	2 PARA	4 PROFESSIONAL	ROW TOTAL
1 STRONGLY AGREE	26	18	4	48
				37.2
2 AGREE	25	27	8	60
				46.5
3 DISAGREE	4	7	5	16
				12.4
4 STRONGLY DISAGREE	2	1	2	5
				3.9
COLUMN TOTAL	57	53	19	129
	44.2	41.1	14.7	100.0

NUMBER OF MISSING OBSERVATIONS = 15

Table 84

FORT POLK

CLINICAL NURSING RECORDS STUDY

"THE INTEGRATED PROGRESS NOTE HAS ENCOURAGED ME TO BE MORE THOROUGH IN DOCUMENTATION"

BY TYPE OF PROVIDER

F2	COUNT	TYPE IRNS 11	PARA 21	ROW TOTAL
STRONGLY AGREE	1	20	18	38
				34.5
AGREE	2	26	25	51
				46.4
DISAGREE	3	10	10	20
				18.2
STRONGLY DISAGRE	4	1		1
				.9
	COLUMN TOTAL	57 51.8	53 48.2	110 100.0

NUMBER OF MISSING OBSERVATIONS = 34

Table 85

FORT POLK

CLINICAL NURSING RECORDS STUDY

"THE INTEGRATED PROGRESS NOTE HAS ENCOURAGED ME TO BE MORE CONCISE IN DOCUMENTATION"

BY TYPE OF PROVIDER

F3	COUNT / TYPE	IRNS (1)	PARA (2)	ROW TOTAL
1 STRONGLY AGREE		23	16	39
				35.5
2 AGREE		29	27	56
				50.9
3 DISAGREE		4	9	13
				11.8
4 STRONGLY DISAGRE		1	1	2
				1.8
	COLUMN TOTAL	57	53	110
		51.8	48.2	100.0

NUMBER OF MISSING OBSERVATIONS = 34

Table 86

FORT POLK

CLINICAL NURSING RECORDS STUDY

"THE INTEGRATED PROGRESS NOTE LESSENS FRAGMENTING OF INFORMATION IN THE PATIENT RECORD"

BY TYPE OF PROVIDER

F4	COUNT / TYPE	RNS (1)	PARA (2)	PROFESSIONAL (4)	ROW TOTAL
1	STRONGLY AGREE	21	13	5	39
					30.2
2	AGREE	30	31	7	68
					52.7
3	DISAGREE	3	9	5	17
					13.2
4	STRONGLY DISAGRE	3		2	5
					3.9
	COLUMN TOTAL	57	53	19	129
		44.2	41.1	14.7	100.0

NUMBER OF MISSING OBSERVATIONS = 15

Table 87

FORT POLK

CLINICAL NURSING RECORDS STUDY

"THE INTEGRATED PROGRESS NOTE LESSENS THE AMOUNT OF INFORMATION EVERYONE MUST DOCUMENT"

BY TYPE OF PROVIDER

F5	COUNT / TYPE	IRNS (1)	PARA (2)	PROFESSIONAL (4)	ROW TOTAL
STRONGLY AGREE	1	23	10	2	35
					27.3
AGREE	2	27	28	4	59
					46.1
DISAGREE	3	5	14	7	26
					20.3
STRONGLY DISAGREE	4	3		5	8
					6.3
	COLUMN TOTAL	58	52	18	128
		45.3	40.6	14.1	100.0

NUMBER OF MISSING OBSERVATIONS = 16

Table 88

FORT POLK

CLINICAL NURSING RECORDS STUDY

"THE INTEGRATED PROGRESS NOTE ENCOURAGES ME TO READ NARRATIVE NURSING NOTES MORE THAN I DID IN THE PAST"

BY TYPE OF PROVIDER

F6	COUNT	TYPE PROFESSIONAL 41	ROW TOTAL
1 STRONGLY AGREE		2	2 10.5
2 AGREE		6	6 31.6
3 DISAGREE		10	10 52.6
4 STRONGLY DISAGREE		1	1 5.3
	COLUMN TOTAL	19 100.0	19 100.0

NUMBER OF MISSING OBSERVATIONS = 125

Table 89

FORT POLK

CLINICAL NURSING RECORDS STUDY

"THE INTEGRATED PROGRESS NOTE MAKES IT EASIER TO DETERMINE WHAT IS HAPPENING WITH MY PATIENT"

BY TYPE OF PROVIDER

F7	COUNT	TYPE: PROFESSIONAL (41)	ROW TOTAL
STRONGLY AGREE	1	2	2
			10.5
AGREE	2	6	6
			31.6
DISAGREE	3	10	10
			52.6
STRONGLY DISAGREE	4	1	1
			5.3
	COLUMN TOTAL	19	19
		100.0	100.0

NUMBER OF MISSING OBSERVATIONS = 125

Table 90

FORT POLK

CLINICAL NURSING RECORDS STUDY

"THE INTEGRATED PROGRESS NOTE HAS SAVED ME TIME IN DOCUMENTING (I FEEL I DON'T NEED TO REPEAT INFORMATION PREVIOUSLY DOCUMENTED BY ANOTHER HEALTH CARE PROVIDER BECAUSE IT'S ALL IN THE SAME PLACE)"

BY TYPE OF PROVIDER

F8	COUNT / TYPE	RNS (11)	PARA (21)	ROW TOTAL
1		25	18	43
STRONGLY AGREE				39.4
2		23	25	48
AGREE				44.0
3		5	7	12
DISAGREE				11.0
4		4	2	6
STRONGLY DISAGRE				5.5
COLUMN TOTAL		57	52	109
		52.3	47.7	100.0

NUMBER OF MISSING OBSERVATIONS = 35

Table 91

FORT POLK

CLINICAL NURSING RECORDS STUDY

"THE INTEGRATED PROGRESS NOTE ENCOURAGES ME TO READ OTHER CARE PROVIDERS' NOTES"

BY TYPE OF PROVIDER

F9	TYPE COUNT / IRNS (1)	PARA (2)	ROW TOTAL
1 STRONGLY AGREE	31	16	47
			42.7
2 AGREE	18	30	48
			43.6
3 DISAGREE	7	6	13
			11.8
4 STRONGLY DISAGRE	1	1	2
			1.8
COLUMN TOTAL	57	53	110
	51.8	48.2	100.0

NUMBER OF MISSING OBSERVATIONS = 34

Table 92

FORT POLK

CLINICAL NURSING RECORDS STUDY

"THE INTEGRATED PROGRESS NOTE SHOULD BE USED AT ALL ARMY HOSPITALS"

BY TYPE OF PROVIDER

F10	TYPE 1 IRNS	PARA 2	PROFESSIONAL 4	ROW TOTAL
1 STRONGLY AGREE	33	21	2	56 / 43.4
2 AGREE	23	27	7	57 / 44.2
3 DISAGREE	1	3	6	10 / 7.8
4 STRONGLY DISAGRE	1	1	4	6 / 4.7
COLUMN TOTAL	58 / 45.0	52 / 40.3	19 / 14.7	129 / 100.0

NUMBER OF MISSING OBSERVATIONS = 15

Table 93

FORT POLK

CLINICAL NURSING RECORDS STUDY

"I HAD LITTLE DIFFICULTY IDENTIFYING WHO WROTE PREVIOUS NARRATIVE NOTATIONS"

BY TYPE OF PROVIDER

F11	COUNT	TYPE: PROFESSIONAL (4)	ROW TOTAL
STRONGLY AGREE	1	4	4
			21.1
AGREE	2	10	10
			52.6
DISAGREE	3	5	5
			26.3
	COLUMN TOTAL	19	19
		100.0	100.0

NUMBER OF MISSING OBSERVATIONS = 125

Table 94

FORT POLK

CLINICAL NURSING RECORDS STUDY

"I HAD NO DIFFICULTY DISTINGUISHING NURSING NOTATIONS FROM THOSE OF OTHER DISCIPLINES"

BY TYPE OF PROVIDER

F12	COUNT	TYPE IRNS 1	PARA 2	PROFES-SIONAL 4	ROW TOTAL
STRONGLY AGREE	1	33	12	4	49
					38.3
AGREE	2	24	30	12	65
					51.6
DISAGREE	3	2	8	3	13
					10.2
	COLUMN TOTAL	59	50	19	128
		46.1	39.1	14.8	100.0

NUMBER OF MISSING OBSERVATIONS = 16

Table 95

FORT POLK

CLINICAL NURSING RECORDS STUDY

"I HAD LITTLE DIFFICULTY LOCATING MY PREVIOUS NARRATIVE NOTATIONS"

BY TYPE OF PROVIDER

"II	COUNT	TYPE PROFESSIONAL 4	ROW TOTAL
STRONGLY AGREE	1	4	4
			21.1
AGREE	2	12	12
			63.2
DISAGREE	3	1	1
			5.3
STRONGLY DISAGREE	4	2	2
			10.5
	COLUMN TOTAL	19	19
		100.0	100.0

NUMBER OF MISSING OBSERVATIONS 125

Table 96

FORT POLK

CLINICAL NURSING RECORDS STUDY

"PHYSICIANS ON MY NURSING UNIT SEEMED TO LIKE HAVING NARRATIVE NURSING COMMENTS INTEGRATED WITH OTHER PATIENT CARE DOCUMENTATION"

BY TYPE OF PROVIDER

	TYPE				
	COUNT	ITNS	PARA		ROW TOTAL
		1	2		
1		14	6		20
STRONGLY AGREE					21.3
2		20	29		49
AGREE					52.1
3		14	2		16
DISAGREE					17.0
4		4	5		9
STRONGLY DISAGREE					9.6
COLUMN TOTAL		52	42		94
		55.3	44.7		100.0

NUMBER OF MISSING OBSERVATIONS = 10

Table 97

FORT POLK

CLINICAL NURSING RECORDS STUDY

"OTHER HEALTH CARE PROVIDERS (e.g., PHYSICAL THERAPIST, DIETITIAN, SOCIAL WORKER) SEEMED TO LIKE HAVING NARRATIVE NURSING COMMENTS INTEGRATED WITH OTHER PATIENT CARE DOCUMENTATION"

BY TYPE OF PROVIDER

TYPE PAGE : 0

FILE	COUNT	IRIS 1	PARA 2	ROW TOTAL
STRONGLY AGREE	1	11	6	17
				19.8
AGREE	2	30	29	59
				68.6
DISAGREE	3	3	3	6
				7.0
STRONGLY DISAGREE	4	2	2	4
				4.7
	COLUMN TOTAL	46	40	86
		53.5	46.5	100.0

NUMBER OF MISSING OBSERVATIONS 58

Table 98

FORT POLK

CLINICAL NURSING RECORDS STUDY

"ALTHOUGH THE GUIDELINES READ THAT ALL NURSING PERSONNEL WERE AUTHORIZED TO CHART ON THE PROGRESS NOTES, THERE WERE SOME EXCEPTIONS TO THIS POLICY ON MY NURSING UNIT"

BY TYPE OF PROVIDER

P16	TYPE COUNT I IRNS	FARM	ROW TOTAL
1 STRONGLY AGREE	6	3	9 8.6
2 AGREE	11	16	27 25.7
3 DISAGREE	28	26	54 51.4
4 STRONGLY DISAGREE	8	7	15 14.3
COLUMN TOTAL	53 50.5	52 49.5	105 100.0

NUMBER OF MISSING OBSERVATIONS 39

Table 99

FORT POLK

CLINICAL NURSING RECORDS STUDY

"IN MY OPINION, THE BOTTOM LINE TO EVERYTHING WE HAVE TESTED IS. . ."

BY TYPE OF PROVIDER

G1	TYPE COUNT / ROW PCT / COL PCT	IRNS 1	PARA 2	LABR CLERK 3	ROW TOTAL
1		111	138	14	263
IMPLEMENT EXACTL		42.2	52.5	5.3	59.1
		42.5	67.6	50.0	
2		3	6	3	12
GO BACK TO OLD		25.0	50.0	25.0	2.4
		1.1	2.9	10.7	
3		147	62	11	220
IMPLEMENT W MODI		66.8	28.2	5.0	44.4
		56.3	30.1	39.3	
COLUMN TOTAL		261	206	28	495
		52.7	41.6	5.7	100.0

NUMBER OF MISSING OBSERVATIONS = 151

Table 100

FORT POLK

CLINICAL NURSING RECORDS STUDY

GENERAL COMMENTS REGARDING THE TEST FORMS

BY TYPE OF PROVIDER

COMMENTS	TYPE: IRN (1)	PARA (2)	WARD CLERK (3)	PROFESSIONAL (4)	ROW TOTAL
1 DR ORDER +GEN SAT	0	4	1	0	5
	0.0	80.0	20.0	0.0	5.2
	0.0	7.7	6.3	0.0	
	0.0	4.2	1.0	0.0	
3 DR ORD+EASY REFER	0	6	2	0	8
	0.0	75.0	25.0	0.0	8.3
	0.0	11.5	12.5	0.0	
	0.0	6.3	2.1	0.0	
4 DR ORD-GEN-PAPERWRK	1	13	5	2	21
	4.8	61.9	23.8	9.5	21.9
	5.9	25.0	31.3	18.2	
	1.0	13.5	5.2	2.1	
5 DR ORD-CONFUS-TIME	10	18	4	3	35
	28.6	51.4	11.4	8.6	36.5
	58.8	34.6	25.0	27.3	
	10.4	18.8	4.2	3.1	
6 DR ORD-MISS ORDERS	9	7	0	1	17
	52.9	41.2	0.0	5.9	17.7
	52.9	13.5	0.0	9.1	
	9.4	7.3	0.0	1.0	
7 DR ORD-STIL TRANSC	0	1	0	0	1
	0.0	100.0	0.0	0.0	1.0
	0.0	1.9	0.0	0.0	
	0.0	1.0	0.0	0.0	
8 DR ORD-MISC PROBLEM	1	3	1	0	5
	20.0	60.0	20.0	0.0	5.2
	5.9	5.8	6.3	0.0	
	1.0	3.1	1.0	0.0	
COLUMN TOTAL	17	52	16	11	96
	17.7	54.2	16.7	11.5	100.0

Table 100

FORT POLK

CLINICAL NURSING RECORDS STUDY

GENERAL COMMENTS REGARDING THE TEST FORMS

BY TYPE OF PROVIDER (CONTINUED)

COMMENTS	TYPE: IRN (1)	PARA (2)	WARD CLERK (3)	PROFESSIONAL (4)	ROW TOTAL
9	2	6	2	0	10
DR ORD 1-SHEET PREFR	20.0	60.0	20.0	0.0	10.4
	11.8	11.5	12.5	0.0	
	2.1	6.3	2.1	0.0	
10	0	2	0	0	2
DR ORD REDISN COMMNT	0.0	100.0	0.0	0.0	2.1
	0.0	3.8	0.0	0.0	
	0.0	2.1	0.0	0.0	
11	2	2	1	0	5
509+ GEN SATISFACT	40.0	40.0	20.0	0.0	5.2
	11.8	3.8	6.3	0.0	
	2.1	2.1	1.0	0.0	
12	0	2	0	0	2
509+IMPROVES COMMUN	0.0	100.0	0.0	0.0	2.1
	0.0	3.8	0.0	0.0	
	0.0	2.1	0.0	0.0	
13	1	2	0	0	3
509+ KEEP	33.3	66.7	0.0	0.0	3.1
	5.9	3.8	0.0	0.0	
	1.0	2.1	0.0	0.0	
14	0	1	0	0	1
509- GEN PROBLEMS	0.0	100.0	0.0	0.0	1.0
	0.0	1.9	0.0	0.0	
	0.0	1.0	0.0	0.0	
15	0	3	0	0	3
509-PARAPROF ENTRY	0.0	100.0	0.0	0.0	3.1
	0.0	5.8	0.0	0.0	
	0.0	3.1	0.0	0.0	
COLUMN TOTAL	17	52	16	11	96
	17.7	54.2	16.7	11.5	100.0

Table 100

FORT POLK

CLINICAL NURSING RECORDS STUDY

GENERAL COMMENTS REGARDING THE TEST FORMS

BY TYPE OF PROVIDER (CONTINUED)

COMMENTS	TYPE: 1 RN	2 PARA	3 WARD CLERK	4 PROFESSIONAL	ROW TOTAL
16	1	1	1	3	6
509-DECR DOCU,LEGAL	16.7	16.7	16.7	50.0	6.3
	5.9	1.9	6.3	27.3	
	1.0	1.0	1.0	3.1	
18	2	0	0	0	2
509-OUT OF SEQUENCE	100.0	0.0	0.0	0.0	2.1
	11.8	0.0	0.0	0.0	
	2.1	0.0	0.0	0.0	
19	2	3	0	0	5
509-CONFUS,FRAGMNT	40.0	60.0	0.0	0.0	5.2
	11.8	5.8	0.0	0.0	
	2.1	3.1	0.0	0.0	
20	4	5	1	3	13
509-NOTES QUALITY	30.8	38.5	7.7	23.1	13.5
	23.5	9.6	6.3	27.3	
	4.2	5.2	1.0	3.1	
21	1	0	0	1	2
509-ID OF SOURCE	50.0	0.0	0.0	50.0	2.1
	5.9	0.0	0.0	9.1	
	1.0	0.0	0.0	1.0	
22	1	4	1	1	7
509 GO BACK TO SEP N	14.3	57.1	14.3	14.3	7.3
	5.9	7.7	6.3	9.1	
	1.0	4.2	1.0	1.0	
36	0	1	0	0	1
3888-5+REDESIGN CMT	0.0	100.0	0.0	0.0	1.0
	0.0	1.9	0.0	0.0	
	0.0	1.0	0.0	0.0	
COLUMN TOTAL	17	52	16	11	96
	17.7	54.2	16.7	11.5	100.0

Table 100

FORT POLK

CLINICAL NURSING RECORDS STUDY

GENERAL COMMENTS REGARDING THE TEST FORMS

BY TYPE OF PROVIDER (CONTINUED)

COMMENTS	COUNT / ROW PCT / COL PCT / TAB PCT	TYPE: IRN (1)	PARA (2)	WARD CLERK (3)	PROFESSIONAL (4)	ROW TOTAL
41 TDS REDESIGN COMMNTS		0	1	0	0	1
		0.0	100.0	0.0	0.0	1.0
		0.0	1.9	0.0	0.0	
		0.0	1.0	0.0	0.0	
42 TDS CODING ISSUES		0	2	0	0	2
		0.0	100.0	0.0	0.0	2.1
		0.0	3.8	0.0	0.0	
		0.0	2.1	0.0	0.0	
45 GEN+SYS CHG CMTS		0	1	0	0	1
		0.0	100.0	0.0	0.0	1.0
		0.0	1.9	0.0	0.0	
		0.0	1.0	0.0	0.0	
46 GEN -CMTS,OLD BETTR		1	3	5	1	10
		10.0	30.0	50.0	10.0	10.4
		5.9	5.8	31.3	9.1	
		1.0	3.1	5.2	1.0	
COLUMN TOTAL		17	52	16	11	96
		17.7	54.2	16.7	11.5	100.0

PERCENTS AND TOTALS BASED ON RESPONDENTS

96 VALID CASES 130 MISSING CASES

Table 101

FORT POLK

CLINICAL NURSING RECORDS STUDY

GENERAL COMMENTS REGARDING DA FORM 3888-2 TEST NURSING HISTORY AND ASSESSMENT

BY TYPE OF PROVIDER

EMPTY DATASET

Table 102

FORT POLK

CLINICAL NURSING RECORDS STUDY

GENERAL COMMENTS REGARDING DA FORM 3888-3 TEST

NURSING HISTORY AND ASSESSMENT CONTINUATION

BY TYPE OF PROVIDER

EMPTY DATASET

Table 103

FORT POLK

CLINICAL NURSING RECORDS STUDY

GENERAL COMMENTS REGARDING DA FORM 3888-4 TEST

NURSING CARE PLAN

BY TYPE OF PROVIDER

EMPTY DATASET

Table 104

FORT POLK

CLINICAL NURSING RECORDS STUDY

GENERAL COMMENTS REGARDING DA FORM 3888-5 TEST

NURSING DISCHARGE SUMMARY

BY TYPE OF PROVIDER

	TYPE		
COMMENTS	COUNT / ROW PCT / COL PCT / TAB PCT	IPARA 2	ROW TOTAL
3888-5+REDESIGN CMT	36 / 100.0 / 100.0 / 100.0	1	1 / 100.0
COLUMN TOTAL		1 / 100.0	1 / 100.0

PERCENTS AND TOTALS BASED ON RESPONDENTS

1 VALID CASES; 225 MISSING CASES

Table 105

FORT POLK

CLINICAL NURSING RECORDS STUDY

GENERAL COMMENTS REGARDING DA FORM 4256-1 TEST DOCTOR'S ORDER SHEET MEDICATION

AND DA FORM 4256-2 TEST DOCTOR'S ORDER SHEET NONMEDICATION

BY TYPE OF PROVIDER

COMMENTS	COUNT / ROW PCT / COL PCT / TAB PCT	TYPE IRN 1	PARA 2	WARD CLERK 3	PROFESSIONAL 4	ROW TOTAL
1 OR ORDER +GEN SAT		0	4	1	0	5
		.0	80.0	20.0	.0	6.7
		.0	9.3	8.3	.0	
		.0	5.3	1.3	.0	
3 OR ORD+EASY REFER		0	6	2	0	8
		.0	75.0	25.0	.0	10.7
		.0	14.0	16.7	.0	
		.0	8.0	2.7	.0	
4 OR ORD-GEN-PAPERWRK		1	13	5	2	21
		4.8	61.9	23.8	9.5	28.0
		7.1	30.2	41.7	33.3	
		1.3	17.3	6.7	2.7	
5 OR ORD-CONFUS-TIME		10	18	4	3	35
		28.6	51.4	11.4	8.6	46.7
		71.4	41.9	33.3	50.0	
		13.3	24.0	5.3	4.0	
6 OR ORD-MISS ORDERS		9	7	0	1	17
		52.9	41.2	.0	5.9	22.7
		64.3	16.3	.0	16.7	
		12.0	9.3	.0	1.3	
7 OR ORD-STIL TRANSC		0	1	0	0	1
		.0	100.0	.0	.0	1.3
		.0	2.3	.0	.0	
		.0	1.3	.0	.0	
8 OR ORD-MISC PROBLEM		1	3	1	0	5
		20.0	60.0	20.0	.0	6.7
		7.1	7.0	8.3	.0	
		1.3	4.0	1.3	.0	

Table 105

FORT POLK

CLINICAL NURSING RECORDS STUDY

GENERAL COMMENTS REGARDING DA FORM 4256-1 TEST DOCTOR'S ORDER SHEET MEDICATION

AND DA FORM 4256-2 TEST DOCTOR'S ORDER SHEET NONMEDICATION

BY TYPE OF PROVIDER (CONTINUED)

COMMENTS	COUNT / ROW PCT / COL PCT / TAB PCT	TYPE IRN (1)	PARA (2)	WARD CLERK (3)	PROFESSIONAL (4)	ROW TOTAL
9 OR ORD 1-SHEET PREFR	COUNT	2	6	2	0	10
	ROW PCT	20.0	60.0	20.0	.0	13.3
	COL PCT	14.3	14.0	16.7	.0	
	TAB PCT	2.7	8.0	2.7	.0	
10 OR ORD REDISN COMMNT	COUNT	0	2	0	0	2
	ROW PCT	.0	100.0	.0	.0	2.7
	COL PCT	.0	4.7	.0	.0	
	TAB PCT	.0	2.7	.0	.0	
COLUMN TOTAL		14 / 18.7	43 / 57.3	12 / 16.0	6 / 8.0	75 / 100.0

PERCENTS AND TOTALS BASED ON RESPONDENTS

75 VALID CASES; 151 MISSING CASES

Table 106

FORT POLK

CLINICAL NURSING RECORDS STUDY

GENERAL COMMENTS REGARDING

DA FORM 4677-1 TEST THERAPEUTIC DOCUMENTATION CARE PLAN NONMEDICATION AND DA FORM 4678-1 TEST THERAPEUTIC DOCUMENTATION CARE PLAN MEDICATION

BY TYPE OF PROVIDER

		TYPE	
	COUNT / ROW PCT / COL PCT / TAB PCT	IPARA 2	ROW TOTAL
COMMENTS			
	41	1	1
TOS REDESIGN COMMNTS		100.0	33.3
		33.3	
		33.3	
	42	2	2
TOS CODING ISSUES		100.0	66.7
		66.7	
		66.7	
	COLUMN TOTAL	3 100.0	3 100.0

PERCENTS AND TOTALS BASED ON RESPONDENTS

3 VALID CASES; 223 MISSING CASES

Table 107

FORT POLK

CLINICAL NURSING RECORDS STUDY

GENERAL COMMENTS REGARDING INTEGRATED PROGRESS NOTES

BY TYPE OF PROVIDER

COMMENTS	COUNT / ROW PCT / COL PCT / TAB PCT	TYPE: IRN (1)	PARA (2)	WARD CLERK (3)	PROFESSIONAL (4)	ROW TOTAL
11		2	2	1	0	5
509+ GEN SATISFACT		40.0	40.0	20.0	.0	14.3
		22.2	11.8	33.3	.0	
		5.7	5.7	2.9	.0	
12		0	2	0	0	2
509+IMPROVES COMMUN		.0	100.0	.0	.0	5.7
		.0	11.8	.0	.0	
		.0	5.7	.0	.0	
13		1	2	0	0	3
509+ KEEP		33.3	66.7	.0	.0	8.6
		11.1	11.8	.0	.0	
		2.9	5.7	.0	.0	
14		0	1	0	0	1
509- GEN PROBLEMS		.0	100.0	.0	.0	2.9
		.0	5.9	.0	.0	
		.0	2.9	.0	.0	
15		0	3	0	0	3
509-PARAPROF ENTRY		.0	100.0	.0	.0	8.6
		.0	17.6	.0	.0	
		.0	8.6	.0	.0	
16		1	1	1	3	6
509-DECR DOCU,LEGAL		16.7	16.7	16.7	50.0	17.1
		11.1	5.9	33.3	50.0	
		2.9	2.9	2.9	8.6	
18		2	0	0	0	2
509-OUT OF SEQUENCE		100.0	.0	.0	.0	5.7
		22.2	.0	.0	.0	
		5.7	.0	.0	.0	

Table 107

FORT POLK

CLINICAL NURSING RECORDS STUDY

GENERAL COMMENTS REGARDING INTEGRATED PROGRESS NOTES

BY TYPE OF PROVIDER (CONTINUED)

	TYPE				
COMMENTS	IRN	PARA	WARD CLERK	PROFESSIONAL	ROW TOTAL
19	2	3	0	0	5
509-CONFUS,FRAGMNT	40.0	60.0	.0	.0	14.3
	22.2	17.6	.0	.0	
	5.7	8.6	.0	.0	
20	4	5	1	3	13
509-NOTES QUALITY	30.8	38.5	7.7	23.1	37.1
	44.4	29.4	33.3	50.0	
	11.4	14.3	2.9	8.6	
21	1	0	0	1	2
509-ID OF SOURCE	50.0	.0	.0	50.0	5.7
	11.1	.0	.0	16.7	
	2.9	.0	.0	2.9	
22	1	4	1	1	7
509 CO BACK TO SEP N	14.3	57.1	14.3	14.3	20.0
	11.1	23.5	33.3	16.7	
	2.9	11.4	2.9	2.9	
COLUMN TOTAL	9	17	3	6	35
	25.7	48.6	8.6	17.1	100.0

PERCENTS AND TOTALS BASED ON RESPONDENTS

35 VALID CASES; 191 MISSING CASES

Table 108

FORT POLK

CLINICAL NURSING RECORDS STUDY

CURRENT DUTY ASSIGNMENT

BY TYPE OF PROVIDER

H1	TYPE IRNS 1	PARA 2	ROW TOTAL
1 CLIN STAFF NURSE	45		45 40.2
2 CLIN HEAD NURSE	8		8 7.1
4 SPEC PRACTICES	3		3 2.7
5 SECT SUPV	1		1 .9
8 91A-AIDE		20	20 17.9
9 91B		2	2 1.8
10 91C PRACT NRS		26	26 23.2
11 91F-PSYCH TECH		7	7 6.3
COLUMN TOTAL	57 50.9	55 49.1	112 100.0

NUMBER OF MISSING OBSERVATIONS = 32

Table 109

FORT POLK

CLINICAL NURSING RECORDS STUDY

"ARE YOU A WARDMASTER?"

BY TYPE OF PROVIDER

		TYPE	
	COUNT	PARA	ROW TOTAL
		21	
H2	1	5	5
YES			9.3
	2	49	49
NO			90.7
	COLUMN TOTAL	54	54
		100.0	100.0

NUMBER OF MISSING OBSERVATIONS = 90

Table 110

FORT POLK

CLINICAL NURSING RECORDS STUDY

PRIMARY INPATIENT NURSING UNIT

BY TYPE OF PROVIDER

H3	TYPE 1 RNS	11 PARA	21 WARD CLERK	31	ROW TOTAL
1 SURG UNIT	7	9			16
					13.0
2 PSYCH UNIT	5	7			12
					9.8
3 MED UNIT	4	2			6
					4.9
4 COMBINED MED SUR	7	7	3		17
					13.8
5 PEDS UNIT	4	6	1		11
					8.9
6 ALL ICU S	9	8	1		18
					14.6
7 L&D NBN POST PAR	18	16	3		37
					30.1
8 OR ANES	6				6
					4.9
COLUMN TOTAL	60	55	8		123
	48.8	44.7	6.5		100.0

NUMBER OF MISSING OBSERVATIONS = 21

Table 111

FORT POLK

CLINICAL NURSING RECORDS STUDY

NUMBER OF YEARS WORKED AS A REGISTERED NURSE

BY TYPE OF PROVIDER

H4

COUNT	TYPE IRNS 11	ROW TOTAL
1	9	9
		17.0
2	11	11
		20.8
3	5	5
		9.4
4	3	3
		5.7
5	1	1
		1.9
6	1	1
		1.9
7	2	2
		3.8
8	3	3
		5.7
10	4	4
		7.5
11	2	2
		3.8
12	1	1
		1.9
13	2	2
		3.8
14	1	1
		1.9
15	4	4
		7.5
16	2	2
		3.8
20	2	2
		3.8
COLUMN TOTAL	53	53
	100.0	100.0

NUMBER OF MISSING

OBSERVATIONS = 91

Table 112

FORT POLK

CLINICAL NURSING RECORDS STUDY

CORPS AFFILIATION

BY TYPE OF PROVIDER

H5	COUNT	TYPE PROFESSIONAL	ROW TOTAL
		41	
AMSC-CIV	1	1	1
			5.3
DC-DIV	2	1	1
			5.3
MC-CIV	3	17	17
			89.5
	COLUMN TOTAL	19	19
		100.0	100.0

NUMBER OF MISSING OBSERVATIONS = 125

Table 113

FORT POLK

CLINICAL NURSING RECORDS STUDY

NUMBER OF YEARS WORKED WITH ARMY INPATIENT

MEDICAL RECORDS/DOCUMENTATION

BY TYPE OF PROVIDER

H6	TYPE COUNT	IRNS 1	PARA 2	WARD CLERK 3	PROFESSIONAL 4	ROW TOTAL
	1	15	12			27
						22.0
	2	13	17	4	3	37
						30.1
	3	6	1		1	8
						6.5
	4	2	3	2	4	11
						8.9
	5		1	1		2
						1.6
	6	1			3	4
						3.3
	7	1	1		1	3
						2.4
	8	2				2
						1.6
	9	1	1		1	3
						2.4
	10	6	3			9
						7.3
	11	1	1		1	3
						2.4
	12	1	1		3	5
						4.1
	13	1				1
(CONTINUED)						.8

Table 113

FORT POLK

CLINICAL NURSING RECORDS STUDY

NUMBER OF YEARS WORKED WITH ARMY INPATIENT

MEDICAL RECORDS/DOCUMENTATION

BY TYPE OF PROVIDER (CONTINUED)

H6	TYPE				
COUNT	IRNS	PARA	WARD CLERK	PROFES-SIONAL	ROW TOTAL
	1	2	3	4	
14	1	2			3
					2.4
15	2	1			3
					2.4
18	1				1
					.8
20		1			1
					.8
COLUMN TOTAL	54	45	7	17	123
	43.9	36.6	5.7	13.8	100.0

NUMBER OF MISSING OBSERVATIONS = 21

Table 114

FORT POLK

CLINICAL NURSING RECORDS STUDY

FINAL GENERAL COMMENTS

BY TYPE OF PROVIDER

COMMENTS	COUNT / ROW PCT / COL PCT / TAB PCT	TYPE: IRN (1)	PARA (2)	WARD CLERK (3)	PROFESSIONAL (4)	ROW TOTAL
GEN+SYS CHG CMTS	45	0	1	0	0	1
		.0	100.0	.0	.0	9.1
		.0	25.0	.0	.0	
		.0	9.1	.0	.0	
GEN -CMTS,OLD BETTR	46	1	3	5	1	10
		10.0	30.0	50.0	10.0	90.9
		100.0	75.0	100.0	100.0	
		9.1	27.3	45.5	9.1	
COLUMN TOTAL		1	4	5	1	11
		9.1	36.4	45.5	9.1	100.0

PERCENTS AND TOTALS BASED ON RESPONDENTS

11 VALID CASES; 215 MISSING CASES

APPENDIX N

Recommended CNR Study Test Form Revisions

MEDICAL RECORD - NURSING HISTORY AND ASSESSMENT

Date and Time of Admission	Admission Diagnosis

	Patient's Own Words When Possible
1. Tell me what you know about your illness / injury / hospitalization.	
2. Do you have any other health problems?	
3. Have you been hospitalized before? If so, when and for what?	
4. What medications have you been taking? (to include prescription and over-the-counter drugs) For how long?	
5 Are you allergic to anything? If so, what? What reaction?	
6 Do you have any special needs that require assistance with daily activities? (e.g. diet, eating, bathing, elimination, ambulating, sleeping; aides or prosthetic devices)	

Name of Local Contact / NOK	Relationship	Telephone Number

Interviewer's Signature, Rank & Title	Informant

PATIENT IDENTIFICATION

PERSONAL ARTICLES AND VALUABLES
(Indicate disposition of each item by initials)

Item	Bedside	Home	Treasurer	Other (Specify)

MEDICAL RECORD - NURSING HISTORY AND ASSESSMENT

ADDITIONAL ASSESSMENT DATA

ADMISSION:	TPR	BP	WT	HT

DATE / TIME:

Signature (Registered Nurse)

ASSESSMENT CATEGORIES:

1 Growth and Development
2 Neurological
- (a) Orientation
- (b) Level of Consciousness; alert, drowsy, lethargic, comatose; Responses: to verbal and painful stimuli; Ability to follow commands; Reflexes
- (c) Describe abnormalities

3. Eyes, Ears, Nose, and Throat
- (a) Eyes: Pupils, vision
- (b) Ears: Hearing, drainage
- (c) Nose: Rhinorrhea, nasal surgery/ trauma
- (d) Throat: Sore, difficulty swallowing, appearance on inspection, lymph nodes
- (e) Describe abnormalities

4. Cardiovascular
- (a) Skin: Color, temp, turgor, moisture
- (b) Peripheral Circulation: Pulses, edema,extremities
- (c) IV's: Contents of bottle hanging, bottle number, condition of site
- (d) Pain: Location, radiation, duration, type, relief
- (e) Intrathoracic tubes and / or dressings

5 Pulmonary
- (a) Respirations: Rate, regularity, effectiveness, depth, use of accessory muscles, nocturnal/exertional dyspnea Chest movement associated with respirations
- (b) Breath sounds: Clear to auscultation, Rales, Rhonchi, Wheezes, etc
- (c) Oxygen: Percent given, liters / min, method of administration, continuous or PRN
- (d) Cough, sputum, suctioning

6. Gastrointestinal
- (a) Abdominal: Auscultation (bowel sounds present), palpitation, abdominal girth measurement (if applicable)
- (b) Dressing and / or drains

7 Genitourinary
- (a) Urination: Continency, pattern change
- (b) Female: Vaginal discharge, LMP, last PAP smear (if applicable), etc.
- (c) Male: Abnormal discharge, swelling, pain

8. Integumentary
- (a) Lesions, pressure points, contractures
- (b) Color, moisture, edema, turgor, change in pigmentation

9. Musculoskeletal
- (a) Movement: Purposeful / Non-purposeful, ROM, muscle strength, level of usual activity
- (b) Foot care (as applicable), TED hose

10. Psycho-Social
- (a) Adjustment to hospitalization and illness, manner, mood, behavior, relation to persons around them

REFERENCE: DA Pam 40-5
AMEDD Standards of Nursing Practice

MEDICAL RECORD - NURSING HISTORY AND ASSESSMENT (CONTINUED)

ADDITIONAL ASSESSMENT DATA

(Continue on reverse side)

PATIENT IDENTIFICATION

MEDICAL RECORD - NURSING HISTORY AND ASSESSMENT (CONTINUED)

ADDITIONAL ASSESSMENT DATA

MEDICAL RECORD - NURSING CARE PLAN

INSTRUCTIONS: Initial each recording.

Date Identified	Problems	Expected Outcomes (Goals)	Date Accomplished

DISCHARGE CONSIDERATIONS:

(CONTINUE ON REVERSE)

PATIENT IDENTIFICATION

MEDICAL RECORD - NURSING CARE PLAN (CONTINUED)

INSTRUCTIONS: Initial each recording.

Date Identified	Problems	Expected Outcomes (Goals)	Date Accomplished

NURSING DIAGNOSTIC CATEGORY GUIDELINES

HEALTH PERCEPTION-MANAGEMENT PATTERN
Health Management Deficit, Total
Health Management Deficit (Specify)
Infection, Potential for
Physical Injury, Potential for
Noncompliance (Specify)
Noncompliance, Potential (Specify)
Poisoning, Potential for
Suffocation, Potential for

NUTRITIONAL-METABOLIC PATTERN
Decubitus Ulcer
Fluid Volume Deficit, Potential
Fluid Volume Deficit, Actual (1)
Fluid Volume Deficit, Actual (2)
Nutrition, Alteration in: Potential for More Than Body Requirements, or Potential Obesity; More than Body Requirements, or Exogenous Obesity, Less Than Body Requirements, or Nutritional Deficit (Specify)
Skin Integrity, Potential Impairment of, or Potential Skin Breakdown
Skin Integrity, Impaired

ELIMINATION PATTERN
Alteration in Bowel Elimination: Constipation or Intermittent Constipation Pattern
Alteration in Bowel Elimination: Diarrhea
Alteration in Bowel Elimination, Incontinence or Bowel Incontinence
Urinary Elimination pattern, Altered
Urinary Elimination, Impairment of, Incontinence
Urinary Elimination, Impairment of: Retention
Stress Incontinence

ACTIVITY-EXERCISE PATTERN
Activity Tolerance, Decreased (Specify Level)
Airway Clearance, Ineffective
Breathing Pattern, Ineffective
Cardiac Output, Alteration in: Decreased
Diversional Activity Deficit
Gas Exchange, Impaired
Home Maintenance Management, Impaired (Mild Moderate Severe, Potential, Chronic)
Joint Contractures, Potential
Mobility, Impaired Physical (Specify Level)
Self-Care Deficit, Total (Specify Level)
Self-Bathing-Hygiene Deficit (Specify Level)
Tissue Perfusion, Chronic Alteration in

COGNITIVE-PERCEPTUAL PATTERN
Cognitive Impairment, Potential
Comfort, Alteration in: Pain
Pain Self-Management Deficit
Knowledge Deficit (Specify)
Sensory Deficit (Specify), Uncompensated
Sensory-Perceptual Alterations: Input Excess or Sensory Overload
Short-Term Memory Deficit, Uncompensated
Thought Processes, Impaired

SLEEP-REST PATTERN
Sleep-Pattern Disturbance

SELF-PERCEPTION--SELF CONCEPT PATTERN
Anticipatory Anxiety (Mild, Moderate, Severe)
Anxiety, Mild
Anxiety, Moderate
Anxiety, Severe (Panic)
Body Image Disturbance
Depression Reactive (Situational)
Fear (Specify Focus)
Personal Identity Confusion
Self Esteem Disturbance

ROLE-RELATIONSHIP PATTERN
Grieving Anticipatory
Grieving, Dysfunctional
Independence-Dependence Conflict, Unresolved
Parenting, Alteration in
Parenting, Potential Alteration in
Social Isolation
Socialization Alterations in
Transplant on Syndrome
Verbal Communication Impaired
Violence, Potential for

SEXUAL REPRODUCTIVE PATTERN
Rape Trauma Syndrome
Rape Trauma Syndrome: Compound Reaction
Rape Trauma Syndrome: Silent Reaction
Sexual Dysfunction

COPING-STRESS TOLERANCE PATTERN
Coping, Family: Potential for Growth
Coping, Ineffective Family: Disabling
Coping, Ineffective Family: Compromised
Coping, Ineffective (Individual)

VALUE-BELIEF PATTERN
Spiritual Distress (Distress of Human Spirit)

REFERENCE
Manual of Nursing Diagnosis, 1983
Marjory Gordon, McGraw Hill Pub Co
Reprinted by permission of McGraw Hill

5 hole top, 3 cy set (1) Inpatient copy (2) Patient's copy (3) Health Record copy

MEDICAL RECORD - NURSING DISCHARGE SUMMARY

Date / Time:	Discharge to: ☐ Home Other (Specify)	Accompanied by:
	Mode: ☐ Ambulatory Other (Specify)	

I. ACTIVITY: ☐ No Restrictions Limitations: (Specify)

_____ Patient and / or Significant Other (S.O) communicates knowledge and understanding of activity limitations

II. DIET: ☐ No Dietary Restrictions If special, identify

_____ Patient / S.O. communicates understanding of dietary restrictions.

III. MEDICATIONS: ☐ No Medication Required

Name of Medication	Dosage	Frequency of Medication	Special Instructions

_____ Patient and / or Significant Other (S O) communicates knowledge and understanding of activity limitations

IV. TREATMENTS / CARE:

Instructions Given:	Patient / S O. Observed Demonstration (Date)	Patient / S O Returned Demonstration (Date)

Equipment / Supplies (Specify)

V. FOLLOWUP: You should be seen in _____ clinic in _____ (time period)

_____ Patient / S O. communicates understanding of followup instructions

VI. PATIENT'S CONDITION (Health Status relative to Nursing Care Plan):

Signature (Registered Nurse)	ADDITIONAL INFORMATION:
PATIENT IDENTIFICATION	

DA FORM 3888-5

CLINICAL RECORD - DOCTOR'S ORDERS

The doctor shall record date, time, and sign each set of orders

USE BALLPOINT PEN - PRESS FIRMLY

MEDICATION ORDERS ONLY (INCLUDES I.V. MEDICATIONS) Date/Time of Order	Time Noted & Transcribed	Time Single Order Done	**NON-MEDICATIONS ONLY** Date/Time of Order	Time Noted & Transcribed	Time Single Order Done

PATIENT IDENTIFICATION

REMARKS

DA FORM 4256

Verify by Initialing		**THERAPEUTIC DOCUMENTATION CARE PLAN *(NONMEDICATION)***		
ORDER DATE	TRANSCRIBER / REVIEWER	SINGLE ACTIONS, DELAYED ORDERS	DATE / TIME TO BE DONE	DATE / TIME COMPLETED
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ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS

PATIENT IDENTIFICATION

CODES :

Initials only = Indicates completion of order
Initials and + = Satisfactory / within normal limits
*Initials and ∅ = Unsatisfactory / Not observed/Omitted**

** See Nurse's note on SF 509*

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN
(NONMEDICATION)

Verify By Initialing				*INITIAL PROPER COLUMN FOLLOWING COMPLETION*									
				DATE COMPLETED									
ORDER DATE	TRANSCRIBER / REVIEWER	RECURRING ACTIONS, FREQUENCY, TIME	HR										
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CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN
(NONMEDICATION)

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				DATE COMPLETED									
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PATIENT IDENTIFICATION:

CODES :

Initials only = Indicates completion of order
Initials and + = Satisfactory / within normal limits
*Initials and Ø = Unsatisfactory / Not observed/Omitted**

** See Nurse's note on SF 509*

THERAPEUTIC DOCUMENTATION CARE PLAN
(NONMEDICATION)

ORDER / EXPIR DATE	TRANSCR REVIEWER	PRN ACTION, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING COMPLETION* TIME / DATE / REASON / INITIALS / RESULTS CODE						

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PATIENT IDENTIFICATION

CODES .

Initials only = Indicates completion of order
Initials and + = Satisfactory/within normal limits
*Initials and ⊘ = Unsatisfactory/Not observed/Omitted**

** See Nurse's note on SF 509*

DA FORM 4677-1 THERAPEUTIC DOCUMENTATION CARE PLAN (NONMEDICATION)

(SIMULATION REDUCED 64%)

3\4" CUT-AWAY TOP

5 HOLES

Verify by Initialing

THERAPEUTIC DOCUMENTATION CARE PLAN *(NONMEDICATION)*

ORDER DATE	TRANSCRIBER / REVIEWER	SINGLE ACTIONS, DELAYED ORDERS	DATE / TIME TO BE DONE	DATE / TIME COMPLETED
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ALLERGIES ☐ YES ☐ NO PRIMARY DIAGNOSIS

PATIENT IDENTIFICATION

CODES

Initials only = Indicates completion of order
Initials and + = Satisfactory within normal limits
*Initials and - = Unsatisfactory / Not observed/Omitted**

* *See Nurse's note on SF 509*

DA FORM 4677-1

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PATIENT IDENTIFICATION

CODES

Initials only = Indicates completion of order
Initials and + = Satisfactory/within normal limits
*Initials and Ø = Unsatisfactory/Not observed/Omitted**

* See Nurse's note on SF 509

THERAPEUTIC DOCUMENTATION CARE PLAN
(NONMEDICATION)

ORDER EXPIR DATE	PATIENT ID #	ACTION FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME DATE REASON / INITIALS RESULTS CODE
		PRN	

AN-14

OVERALL SIZE 17" X 11"

5 HOLES

3\4" CUT-AWAY TOP

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN
(NONMEDICATION)

Verify By Initialing

INITIAL PROPER COLUMN FOLLOWING COMPLETION

DATE COMPLETED

ORDER DATE	RANGE OF ORDER	RECURRING ACTIONS FREQUENCY TIME	HR
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PATIENT IDENTIFICATION

CODES

Initials only = Indicates completion of order
Initials and + = Satisfactory - within normal limits
Initials and - = Unsatisfactory - Not observed Omitted*

* See Nurse's note on SF 509

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N-15

Verify by Initialing		**THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)***		
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ALLERGIES: ☐ YES ☐ NO	PRIMARY DIAGNOSIS:

PATIENT IDENTIFICATION:

CODES :

Initials only = Indicates medication was administered
Initials and E = Effective
*Initials and I = Ineffective **
*Initials and ∅ = Medication was not administered as ordered **

** See Nurse's note on SF 509*

CLINICAL RECORD		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)											
Verify By Initialing				*INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION*									
				DATE COMPLETED									
ORDER DATE	TRANSCRIBER REVIEWER	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR										
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CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN
(MEDICATIONS)

Verify By Initialing				*INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION*									
				DATE DISPENSED									
ORDER DATE	TRANSCRIBER REVIEWER	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR										
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PATIENT IDENTIFICATION

CODES

Initials only = Indicates medication was administered
Initials and E = Effective
*Initials and I = Ineffective **
*Initials and N = Medication was not administered as ordered **

** See Nurse's note on SF 509*

THERAPEUTIC DOCUMENTATION CARE PLAN
(PRN MEDICATIONS)

ORDER EXPIR DATE	TRANSCR REVIEWER	PRN MEDICATION, DOSE, ROUTE, FREQUENCY, REASON	*INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION* TIME / DATE / REASON / INITIALS / EFFECTIVENESS CODE						

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PATIENT IDENTIFICATION

CODES .

Initials only = Indicates medication was administered
Initials and E = Effective
*Initials and I = Ineffective **
*Initials and ∅ = Medication was not administered as ordered **

** See Nurse's note on SF 509*

DA FORM 4678-1 THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATION)

(SIMULATION REDUCED 64%)

3\4" CUT-AWAY TOP

5 HOLES

Verify by Initialing

THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*

ORDER DATE	TRANSCRIBER / REVIEWER	SINGLE ACTIONS DELAYED ORDERS PREOPERATIVES	DATE / TIME TO BE GIVEN	DATE GIVEN / TIME / INITIALS
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ALLERGIES ☐ YES ☐ NO

PRIMARY DIAGNOSIS

PATIENT IDENTIFICATION

CODES

Initials only = Indicates medication was administered
Initials and E = Effective
Initials and I = Ineffective *
Initials and = Medication was not administered as ordered *

* See Nurse's note on SF 509

DA FORM 4678-1

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D

PATIENT IDENTIFICATION

CODES:

Initials only = Indicates medication was administered
Initials and E = Effective
Initials and I = Ineffective *
Initials and " = Medication was not administered as ordered *

* See Nurse's note on SF 509

THERAPEUTIC DOCUMENTATION CARE PLAN
(PRN MEDICATIONS)

ORDER/ EXPIR DATE	TRANSCR / REVIEWER	PRN MEDICATION, DOSE, ROUTE, FREQUENCY, REASON	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION: TIME / DATE / REASON / INITIALS / EFFECTIVENESS CODE

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OVERALL SIZE 17" X 11"

5 HOLES

CLINICAL RECORD — **THERAPEUTIC DOCUMENTATION CARE PLAN** *(MEDICATIONS)*

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Verify By Initialing				*INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION*									
				DATE DISPENSED									
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PATIENT IDENTIFICATION

CODES
Initials only = Indicates medication was administered
Initials and E = Effective
*Initials and I = Ineffective **
*Initials and ' = Medicatic was not administered as ordered **

** See Nurse's note on SF 509*

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3\4" CUT-AWAY TOP

CLINICAL RECORD — **THERAPEUTIC DOCUMENTATION CARE PLAN** *(MEDICATIONS)*

(B)

Verify By Initialing				*INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION*									
				DATE COMPLETED									
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