A STUDY OF THE RELATIONSHIP BETWEEN PROBLEM-ORIENTED RECORDS USING NURSING DIAGNOSES AND A QUALITY OF NURSING CARE

BY

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CHAPTER I

INTRODUCTION

The planning, implementation, maintenance, and evaluation of programs is indigenous to the domain of the administrator. A significant portion of the daily decision-making activity is in regard to the various programs occurring within the organization. It is most helpful to the administrator if explicit information regarding the functioning of these programs is available (Knapp, 1979; Rossi, 1979).

A nursing service department in a metropolitan health sciences center hospital has been gradually implementing the use of problem-oriented records (POR) and nursing diagnoses (ND). One of the goals articulated for this program is that it will advance and elevate the quality of patient care (Problem-Oriented Record Module, 1980). This goal is consistent with the large body of literature on problem-oriented records (Kinney, 1974; Leonard, 1974; Mitchell, 1973) and nursing diagnoses (Gordon, 1978; Roy, 1975). Much of this literature is conjectural and anecdotal in nature, however, and the need for sound research to support the theory is evident.

The question of whether the use of POR and ND do, in fact, improve the quality of patient care is relevant to the nursing administration at the hospital involved in this study and to the nursing profession in general. To obtain this information, however, it is first necessary to examine whether or not a linkage exists between the quality of the record and the quality of care. This study attempted to explore that relationship. The question of whether care actually improves as a

result of using POR and ND is one that must be addressed at another time. The guiding question to this study, then, was what is the relationship that exists between the quality of the problem-oriented record using nursing diagnoses and the quality of nursing care received by patients. The data generated by this study should be useful to nurse administrators. It should also provide a solid basis on which to build further research in this area.

Review of the Literature

The following literature review includes 1) the problem-oriented system and record, 2) the nursing process, 3) nursing diagnoses, and 4) the use of quality of care measures for assessing the relationship between POR/ND and the quality of nursing care.

Problem-Oriented Concept

System. The problem-oriented concept traces its origins to a physician by the name of Lawrence Weed. It first appeared in 1964 in the Irish Journal of Medical Science and addressed such issues as the chaotic nature of source-oriented records, the need for self-discipline, the problems of "cook-book" and memory-based approaches to medical education, the need for audit, and the need for public accountability (Hanchett, 1977). Over the next several years and in subsequent publications, the concept grew and the specifics of what appeared to be a rational, logical, efficient system began to emerge (Hanchett, 1977; Hurst, 1971).

In the broader perspective, the problem-oriented system includes principles of practice, the problem-oriented record, audit, and educational programs (Walker, 1973). It embodies much more than a method of record keeping; it is a whole philosophy of patient care (Lambert,

1974a). That philosophy views patient care as a coordinated, multi-disciplinary effort--not just nursing care or medical care (Easton, 1974; Mitchell, 1973; Thompson, 1974).

The system strives for simple, accurate, logical, and ordered collection of patient data for the purpose of identifying, at a given point, all of a patient's health problems, the appropriate treatment, and the patient's response. Such a system lends itself well to evaluation of care. This evaluation is an important component of the problem-oriented philosophy (Neelon, 1974; Easton, 1974). The cycle of problem identification, treatment and evaluation may stimulate improved quality of care.

The POR system is meant to be fluid, constantly changing (Twin, 1974, p. 27). It is also meant to be adaptable to a variety of health care settings (Lambert, 1974a).

System goals include increasing the visibility of 1) interaction of the patient's problems; 2) patient's response to treatment received; and 3) the quality of care (Hanchett, 1977, p. 83-4). Hurst (1971) adds to this list of goals improved communication among health professionals and improved education of those working with the system.

These goals clearly reflect the philosophy underlying the whole POR system. It is the efficient functioning of all the components of the system together to accomplish the above goals which is suggested to result in better quality of patient care (Atwood, 1974; Gane, 1973; Hurst, 1971; Lambert, 1974a; Shaughnessy, 1979). The record itself is the central element to the system but it is not the record which is proposed to improve the quality of care. It is the use of the record for education, audit and practice which may result in the better quality

of care.

Record. The problem-oriented record is the element of the system around which the other elements revolve. It provides the link between education, audit, and patient care (Hurst, 1972). It also serves as a significant medium for communication of patient data among the various members of the health team (Easton, 1974).

There are four principal parts to the POR: the data base, the problem list, the plans, and the progress notes (Twin, 1974). The data base includes the patient's history, physical exam, lab reports, and xrays. From it, the problem list is generated. The problems are numbered and are continually updated as the patient's status changes. The plans are then structured for each problem and are identified with the problem by number and title. The progress notes include narrative notes, flow sheets and discharge notes.

The narrative notes document outcomes of the plans. They are also numbered, titled and identified with a problem. The following format is usually used:

S- Subjective--How does the patient feel? What does the patient say with respect to a given problem?

O- Objective--Physical exam, lab test, observations by the health professional.

A- Assessment--of the situation to date.

P- Plans--Leave the same? Change? What is to be done to further diagnose, treat, and educate the patient?

The premise that the use of the POR, within the context of the system, will improve care is not unconditionally accepted by all. Feinstein (1973) asserts that many of the apparent advantages of the

POR arise from the enthusiasm and supervision with which the new system is applied rather than from the problem-structured format. (His list of illusory advantages includes improved continuity of patient care, the idea of using the POR as an index of quality in health care, improved integration of professional personnel, and the concept that the POR will promote continuing audit of patient care.) He contends that adherence to a new format does not necessarily alleviate the intellectual ills that currently plague the health care system. Feinstein's criticism, however, centers on the problem-oriented record itself rather than on the system.

Goldfinger (1973) also draws attention to some of the potential deficiencies of the POR. He contends that 1) it is possible to have excellent problem-oriented recording of atrocious medical care, 2) what constitutes the ideal data base is unknown, 3) needed data cannot always be retrieved from an isolated segment of the record, 4) there is too little emphasis on accuracy of the displayed data, 5) inconsistent quality of entries by the various health personnel add confusing bulk to the record, 6) the inductive method by which problems are formulated is an imperfect one and creates problems for computer storage that are not remedied by the POR; and 7) it is tenuous to suppose that POR will greatly facilitate peer review or clinical judgment. "It is substance, rather than style, that is most needed" (Goldfinger, 1973, p. 608).

While rhetoric on the POR system goes on ad infinitum, there is a paucity of research to lend objectivity to the many premises which have been offered. The following paragraphs describe the few studies which have been done in this area.

Bloom, et al (1971) audited the problem-oriented records of 15

patients over a four week period to determine how well the system was being utilized, and evaluated quality of patient care by chart content analysis using a "Standard for Nursing Care Checklist" developed at the University Hospital of Washington. The results indicated a lack of clarity in staff articulation of impressions, goals, actions, and evaluations of actions. Patient care was rated as improved over a four week period. Specifics of the statistical analysis were not given. The sample size, short time frame and absence of control variables or groups weaken the study.

Asp and Brashear (1973) did three audits to evaluate the use of POR in a community hospital. One was a subjective audit of physicians and nurses which revealed perceived improvement in patient care as a result of problem-oriented records. Another audit of the quality of care delivered to patients with specific diseases was done on both traditional records and problem-oriented records. No statistical differences were found. The authors attributed these results to a small sample size and limited time frame. It should be noted here that the assumption was made that the records accurately reflected the quality of care delivered. This may or may not be true (Donabedian, 1966).

Results of studies comparing the effective application of source-oriented records and problem-oriented records have been mixed. Aranda (1974) and Switz (1973) found no significant difference in the number of problems identified or the availability of relevant information. Thoma (1972), Savett (1973) and Bertucci (1974) found the POR superior in both of these areas. In all of these studies, the records were viewed as a reflection of the actual patient care. No attempt was made to directly evaluate that care.

So, the need for sound studies to substantiate the claims for POR is evident. The results of the ones now in print are contradictory and the basic question of whether the use of the problem-oriented system is related to the quality of patient care remains unanswered.

Nursing Process

Weed's focus was, understandably, medical and medical records. His system, however, promised to be applicable to the records of all health care professionals. It lent itself especially well to nursing because of its close similarity to the nursing process. "Both are, in essence, methods of structuring information toward more efficient goal-directed behavior" (Hanchett, 1977, p. 21).

The nursing process is composed of four elements: assessment, planning, intervention, and evaluation (Abruzzese, 1974; Marriner, 1979). Assessment, the first phase of the process, identifies and diagnoses patient's problems utilizing data about the health status of the patient. During the planning phase the nursing diagnoses are used as the basis for developing and prioritizing patient care goals and objectives. The nursing interventions for each diagnosis are based on the goals and objectives. The third phase, implementation or intervention, is the care giving phase. It is guided by the plan. Recording of patient status, nursing interventions and patient response to interventions is essential. Evaluation, the fourth phase, is a continuous feedback process wherein adequacy of assessment and planning are judged in relation to patient outcomes. An accurate, orderly record of each component of the process makes such evaluation feasible. The POR seems to fill this need (Marriner, 1979).

Nursing Diagnoses

Definition. A key element in the nursing process is the nursing diagnosis which is generated during the assessment phase. The term "Nursing Diagnosis" has been in nursing literature since 1950 when it was used by McManus to help describe the functions of the professional nurse (Lash, 1978). Initially, it was a rather vague entity which somehow summarized all of an individual patient's needs (Fry, 1953) and was frequently used interchangeably with the terms "problem" and "need" (Bloch, 1974). Komorita (1963, p. 84) defined the term as:

> a conclusion based on scientific determination of an individual's nursing needs, resulting from critical analysis of his behavior, the nature of his illness and numerous other factors which affect his condition.

This definition implies judgment--judgment based on a sound body of knowledge (Komorita, 1963). Such a body of knowledge should contain a typology of nursing problems and procedures of nursing practice based upon principles of nursing or related science (Abdellah, 1960). It began to be recognized that nursing diagnoses must be more than a list of patient problems based on subjective evaluation or intuitive hunches. Nursing diagnoses must be representative of a body of scientific knowledge.

Later, nursing diagnosis was briefly defined as "the judgment or conclusion which occurs as a result of nursing assessment" (Gebbie, 1975, p. 70). This definition, however, proved to be too vague and nonspecific to be useful in the clinical setting (Moritz, 1982). A more specific definition was developed by Gordon (1978, p. 1298-99) which states:

> Nursing diagnoses, or clinical diagnoses made by professional nurses, describe actual or potential

> health problems which nurses, by virtue of their education and experience, are capable and licensed to treat.

She describes these health problems generally as those which "encompass potential or actual disturbances in life processes, patterns, functions, or development, including those occurring secondary to disease". She goes on to develop a structural definition which identifies the elements of the diagnostic process--the problem, etiology, and signs and symptoms.

These definitions demonstrate that the concept of nursing diagnosis is gradually developing to a higher conceptual level and is increasing in its usefulness at a practical level.

National Conferences. Medicine has been developing its diagnostic taxonomy along with its care for centuries. Nursing, however, has just recently begun this task. The absence of a nursing diagnostic taxonomy is a severe handicap to the profession (Carnevali, 1976) and nurses are painfully aware that this problem exists.

Currently, there is a coordinated effort nationally to develop a classification system that identifies, labels and categorizes all the patient concerns which are addressed by nurses (Fortin, 1979; Gebbie, 1974; Gordon, 1980a; Roy, 1975). It began in the early 1970's with a burgeoning of interest in developing a taxonomy for nursing. In 1973, the first of a series of National Conferences on the Classification of Nursing Diagnoses was held. It was composed of 100 nurses from education and clinical practice who met in small task groups to identify nursing diagnoses. Work done in the subsequent conferences and in intervening studies has resulted in 42 nursing diagnoses with their defining characteristics and common etiological factors (Appendix H).

Quality of Care. Much of the literature on ND suggests that there is a positive relationship between the use of ND and the quality of care delivered to patients (Gordon, 1978; Kim, 1982; McCourt, 1982; Roy, 1975). The research to support the contention, however, is limited (Kim, 1982).

One study was done by Kim, et al (1982) using 49 junior year baccalaureate nursing students enrolled in a 10-week medical-surgical nursing course offered at a major university. A questionnaire was distributed which solicited student opinions on how they identified and used ND. One of the areas addressed concerned the student's perceptions of the effect of using ND on the quality of patient care. The results indicated that the student's believed ND was of value in each phase of the care planning process. Once students identified the ND, they were able to select appropriate nursing interventions. No actual measures of quality of care were done. The inference was made from these results that the use of ND in the care planning process will affect the outcomes and quality of patient care.

The relationship between ND and quality of care in this study is an inferred one. No other studies were found which addressed this relationship. The need for further research is evident.

Quality of Care Measures

Definition. There was a time in nursing history when evaluation of nursing care was couched in terms of quantities--i.e. time and task studies. Improvements in methodologies, however, have switched the focus to evaluation of quality (Van Maanen, 1979). The concept of quality is difficult to define as it is quite abstract. The translation of the abstraction into tangible terms constitutes the difficulty.

The failure of time and tasks studies to accurately reflect nursing care indicated that elements of nursing such as values, beliefs, and expectations do not lend themselves to quantification. Van Maanen (1979, p. 382) identified two elements which must be considered in evaluation of nursing care.

1) Value judgments.
2) A concept about nursing and nursing care.

The definition of quality nursing care is best established by nurses who are recognized as experts by their peers. It may relate to one or all three areas that are related to the quality of nursing care. These are:

1) The specific practices or interventions that constitute professional nursing.

2) The characteristics of the setting or the conditions conditions under which nursing care is delivered.

3) The effects of both on the consumer of nursing or patient (Hagan, 1976).

Description. The available quality of care measures fall basically into three categories or combinations of the three. These categories are structure, process, and outcome measures (Donabedian, 1966). Structure refers to the elements of the system which contribute to patient care such as the physical facilities, staffing patterns, styles of supervision, and characteristics of the care givers. Process has to do with the overt and cognitive behaviors of the care giver. Outcome measures analyze the results of care in terms of changes in the recipient of that care (Bloch, 1975).

Strengths and weakness. Of the three frameworks for evaluation, outcome would probably be ideal, but as Stevens (1979, p. 223) states,

> ...such criteria are difficult to identify at the present developmental level of nursing research.

> To use outcomes as criteria, one would have to be able to determine how much of the patient's return to wellness was due to nursing and how much was due to medicine.

The structural framework is the easiest to measure in that it deals with such factors as the number of staff, condition of facilities and equipment. Its major weakness is that the relationship between structure and process or outcome is often questionable (Donabedian, 1966). The presence of the structures necessary for quality patient care does not necessarily assure that care actually occurs (Stevens, 1979).

Process measures may use primary or secondary sources. A primary source would be direct observation of care as it is given. A secondary source would be an audit of the patient's records (Stevens, 1979). As a rule the secondary source is more accessible and less expensive to evaluate than the primary source. The weakness of the secondary source is in the assumption that the record accurately reflects all that was done for the patient. This may or may not be true (Donabedian, 1966). The direct observation method, a primary source, is a more time consuming, expensive measure, but bypasses possible inconsistencies in the record.

Summary

This literature review has demonstrated that the POR works within the framework of a system--a system with an underlying philosophy which values patient care as a coordinated, multidisciplinary effort. It strives for a simple, accurate, logical and ordered system for collection of patient data and the communication of that data to the whole health care team for the purpose of identifying all of a patient's

health problems, the appropriate treatment, and the patient's response. Most writers assume that the POR facilitates such coordination and communication. It is also assumed that the POR system is better than the traditional source-oriented system and that this difference results in improved quality of care.

Two elements of this system which play an important role in the adaptation of the system to nursing are the nursing process and nursing diagnosis. As was noted earlier, the nursing process lends itself well to the POR format since both are rational ways for ordering information toward more efficient goal-directed behavior (Hanchett, 1977). A critical link in the nursing process is the nursing diagnosis. It was defined as the conclusion, drawn from the relevant data, of an individual's nursing needs (Komorita, 1963). This conclusion represents not only the culmination of the nurses' judgment based on the data, but the means by which this judgment is communicated throughout the health care team. The projected outcomes and plan of therapy to attain those outcomes are based on accurate diagnosis of the problems (Gordon, 1978).

The literature on nursing diagnosis claims that there is a positive relationship between the quality of nursing care and the use of ND. One study was found which inferred that this is so (Kim, 1982). This inference was based on student's opinions. No actual measures of patient care or the use of ND were done.

Quality of nursing care proved to be a difficult concept to define. Two elements which must be considered in any definition were identified by Van Maanen (1979) as 1) value judgments and 2) a concept about nursing and nursing care. Nurses, then, who have been recognized as experts

by their peers should establish the definition of quality nursing care.

The available measures for quality of care fall into three categories: structure, process and outcome. Each of these were described and their strengths and weaknesses identified.

Purpose of the Study

The purpose of the present study is to contribute to the evaluation of the relationship between the use of problem-oriented records in combination with nursing diagnoses and the nursing care received by patients.

Hypothesis

There will be a positive relationship between the quality of care received by patients as measured by a combined direct/indirect observation method and the quality of records using problem-oriented charting and nursing diagnoses.

CHAPTER II

METHODOLOGY

This was a descriptive study, the purpose of which was to investigate the relationship between problem-oriented records using nursing diagnoses and the quality of nursing care received by patients. The data collected from this study was used to aid in the evaluation of a POR/ND program implemented at a metropolitan teaching hospital. One of the objectives of the program was to advance and elevate the quality of patient care. Before this objective could be evaluated, it was necessary to determine whether a positive relationship existed between quality of care and quality of the record.

The tools used in this study were the Quality of Patient Care Scale or Qualpacs and a records audit. The Qualpacs is an instrument which has been designed to measure the quality of nursing care received by patients. The audit is a measure of how well the POR and ND were being utilized. A correlational design was used to see what relationship existed between the quality of care received by patients and the problem-oriented record using nursing diagnoses.

Setting

The setting for this study was a 500 bed hospital in a large metropolitan area. It is a teaching hospital with full university affiliation. This hospital was chosen because it was in the process of implementing problem-oriented recording and nursing diagnoses in its patient care units. The patient care unit studied was selected because all staff were using POR and ND.

Data Collecting Instruments

Qualpacs

One of the instruments selected for this investigation was the Quality of Patient Care Scale, or Qualpacs. It was designed to measure the quality of nursing care received by patients in any setting where nurses interact with patients. This includes interactions with persons responsible to and supervised by nursing personnel as well. It is predominantly a direct observation method which quantifies the quality of care (Wandelt & Ager, 1974).

The Qualpacs consists of 68 items of nursing care in six major categories (Appendix A). These categories are:

I. Psychosocial-Individual: Actions directed toward meeting psychosocial needs of individual patients.

II. Psychosocial-Group: Actions directed toward meeting psychosocial needs of patients as members of a group.

III. Physical: Actions directed toward meeting the physical needs of patients.

IV. General: Actions that may be directed toward meeting either psychosocial or physical needs of the patient, or both at the same time.

V. Communication: Communication on behalf of the patient.

VI. Professional Implications: Care given to patients reflects initiative and responsibility indicative of professional expectations (Wandelt & Ager, 1974, p. xi).

The items are not listed in any order of rank. There is a set of symbols following each item which is provided as a point of reference for the rater. They are as follows:

#D: Observation that permits rating will usually be direct observation of an interaction.

#I: Observation that permits rating of the items will usually be indirect: e.g., a notation in the record or information for nurses, patient, or family.

#D/I: Observation may be either direct or indirect (Wandelt & Ager, 1974, p. 37).

The rating spaces to the right of each item are on a five point scale and allow for multiple ratings of a single item if necessary. The ratings were accomplished during two-hour observation periods by two nurses who were competent to make judgments on the quality of the nurse-patient interactions. The standard for measurement of quality that was used was that expected of a first level staff nurse.

To assist the raters in making accurate, consistent judgments, the Qualpacs has a set of cue sheets (Appendix B). The cues provide concrete examples or descriptions of each of the 68 items of nursing care. They also serve as reminders of the kinds of activities that may be rated by one or more items. The cues are not meant to be static. Each observer/rater may add or delete cues to suit the particular situation. They were reviewed before and during each observation period as reminders (Wandelt & Ager, 1974).

In addition to the cue sheets, each rater used an Individual Frame of Reference (Appendix C) as a standard of performance throughout the study. This form indicates by name the nurse that the rater believes

best typifies nursing practice in each of the five levels of care: Best Staff Nurse; Between: Average Staff Nurse; Between: and Poorest Staff Nurse. The Average Staff Nurse was defined as one who delivers safe, adequate, therapeutic and supportive direct patient care. Best Staff Nurse, then, was defined as one who delivers the most comprehensive, therapeutic, supportive, and safe care. Poorest Staff Nurse was one who delivered care that was inadequate, non-therapeutic, not supportive, and/or unsafe. The Between's were defined within the context of these three types of nurses. This standard of care was applied regardless of the category of staff delivering the care.

The score for each item was calculated following each observation session. This was done by totaling the scores for each interaction in the item and dividing by the number of interactions. An interaction receiving a score of "Best Care" received a score of one. The columns "Between", "Average", and "Between" received scores of four, three, or two respectively. This score was entered in the space below and to the right of the diagonal in the Mean Score column. Items marked "Not Observed" or "Not Applicable" were not counted in the calculations.

The mean scores for each of the six major areas were then calculated. This was done by adding the mean scores of all items rated in the category and dividing by the number of items rated.

The Grand Mean Score is the measure of the quality of nursing care received by the patient. It was calculated by adding the mean score of all the items rated, dividing by the number of items rated, and carrying this number to one decimal place. Again, items marked in the "Not Applicable" or "Not Observed" columns were not counted in the calculation of the Grand Mean Score (Wandelt & Ager, 1974). This resulted in

a number between one and five.

Two different forms of reliability were estimated. During a pilot study with six subjects, interrater agreement was established by correlating the Grand Mean scores from the two nurse-raters. A positive correlation of .795 was found. Internal consistency was determined for Qualpacs by analyzing data from the 30 subjects in the main study. The result was an alpha reliability of .96.

Audit

A records audit was done to determine the extent to which POR and ND were being utilized on the experimental unit (Appendix G). The records of each patient observed were audited for the 72 hours prior to observation time or from the time of admission, whichever occurred first. The audit employed for this study was based on one which was currently being utilized by the nursing administration to assess the use of the POR/ND system. The assumption was made that the record would accurately reflect the extent to which the system was being used. The audit was concerned only with the contributions made by nurses as the system had not yet been introduced to other members of the health care team. This was one of the deficits of the system as it was being employed and may have had impact on the results.

The audit consists of 24 items concerning the use of POR and ND (Appendix G). An assumption was made in the scoring system that all items were of equal importance. The investigator recognizes that this is not necessarily true, but at this stage in nursing research there is not sufficient information available to determine how to weigh the items. Therefore, all items were weighted equally. Each item was rated on a scale of 0-2 wherein (0) indicated the item did not occur at all, (1)

meant the item was used, but not always, and (2) indicated the item was used 100% of the time.

The potential range of scores on the audit was 0 to 48 with 0 indicating none of the items occurred at all and 48 showing all items were used 100% of the time. The higher score, then, indicated a better quality of record and lower scores vice versa. A Grand Total score was computed on each audit by totaling the item scores. This is the score which was correlated with the Grand Mean from the corresponding Qualpacs observation.

Interrater agreement was also established on the audit during a pilot study. The result was a correlation of .997. The alpha reliability was computed from the data collected in the main study to establish internal consistency. The result was a score of .96.

Incidental Data

In addition to the Qualpacs and audit, information on the staffing levels of the unit during the time of observation and audit was collected. Approximately 10 different staff members were observed during the duration of the study. The unit was predominantly staffed with RN's with one aide, one clerk, and one LPN working intermittently. Table 1 summarizes the staffing levels.

Table 1

Staffing Levels

	Mean	Mode	Minimum No.	Maximum No.
RN	3.37	3.00	3.00	4.00
LPN	0.03	0.00	0.00	1.00
SN	0.00	0.00	0.00	0.00
AIDE	0.73	1.00	0.00	1.00
CLK	0.53	1.00	0.00	1.00

Subjects

The 30 patients observed on the 20 bed unit of study over a four week period were randomly selected through the use of a table of random numbers. Eligibility for inclusion in the study was determined by five criteria developed by Preston (1977) and used by Peterson (1980, p. 17). These criteria were:

1) Individual patient observations generating ratings on 30 items are eligible for inclusion. Ratings of 30 items are necessary to a reliable measurement of the quality of care received.
2) Patients whose observation reveals less than four nurse interactions during the two-hour period of study will be excluded.
3) Patients must remain in the care area during the entire observation period.
4) The same patient may be observed on two tours.

Wandelt and Ager (1974) state that by deriving a mean score from the scores of as few as five patients, or fifteen percent, whichever is greater, a valid and reliable measurement may be generated. Thirty patients were observed and their charts audited for this study. This number was chosen in order to increase the power of the study above that which is allowed by the minimum standard for observation. Table 2 summarizes these patients according to their level of care.

Table 2

Levels of Care of Subjects

	Level 1 Min. Care	Level 2 Mod. Care	Level 3 Heavy Care
No. of Patients	6	18	6

The levels of care of the total unit census for all of the evenings during which observations occurred revealed a similar distribution (Table 3). During the study period, nearly two-thirds of the subjects were categorized as level 2 patients with the other third being distributed evenly between levels 1 and 3.

Table 3

Total Unit Census

Level of Care	Min. No. of Patients	Max. No. of Patients	Mean	Median	Standard Deviation
1	2	4	2.93	2.93	.740
2	7	14	10.60	10.27	1.499
3	2	5	4.13	4.67	1.106

Data Collection Procedure

Permission to conduct this study was requested from nursing administration and the head nurse of the unit selected for the study. A Fact Sheet About Qualpacs (Appendix D), which briefly describes Qualpacs and the procedure for its use was distributed to the above individuals as well as to the staff on the study unit. The nurse raters met with these individuals prior to the study to identify themselves and answer questions. The verbal consent of the staff was solicited prior to each observation period. Details of the study, including its purpose, process of data collection, and procedures of the study were presented in detail to the Quality Assurance Committee and POR Committee. Patients participating in the study were requested to sign a consent form prior to observation (Appendix E).

The two nurse raters prepared for use of the Qualpacs by reading the scale, guide, and cue sheets. In addition, they viewed the film "Preparing the Nurse Observer to Use the Quality Patient Care Scale"

(Buffalo Veterans Administration Hospital, 1978).

In order to further prepare the raters and to obtain interreliability estimates, a pilot study was conducted using the same nurse raters as were used in the actual study. The raters prepared for each observation by completing the Information Face Sheet and the Rater's Notes for Assessment and Planning Care (Appendix F). After this was done, the nurse-raters introduced themselves to the patient, explained briefly the purpose of the observation and that interaction must not occur between the raters and the patient. The patients were informed that at the completion of the observation period the raters would answer any questions and provide more details of the study if the patient desired. The informed consent (Appendix E) was given to the patient and his/her signature was obtained prior to observation.

The raters simultaneously observed with patients over a period of six days. A total of eight patients were randomly selected and set the inclusion criteria for the study. The observation periods lasted two hours and represented evening shift only. The first two patients were observed jointly, and rated jointly. The last six were simultaneously observed, but rated individually. Following each two-hour observation period, any additional necessary data was collected from the chart or by talking with the appropriate personnel.

The chart audit was done prior to each observation. All the items on the audit were considered applicable to every chart, so each was scored accordingly. As with the Qualpacs, the first two were done jointly. The last six individually.

Once interrater reliability was established, the actual study began. It followed the same procedure as the pilot study except that each

patient was observed by only one rater.

To assure accuracy of observations, the raters used a system of notes during the observations. These notes recorded in chronological order the interactions that occurred. In this way, the raters referred to the notes to rate the interactions in retrospect if interactions occurred too rapidly to make simultaneous ratings (Peterson, 1980; Preston, 1977).

If an item did not apply to a given patient, "Not Applicable" was marked. When an expected activity was not observed, "Not Observed" was noted. If no evidence existed that this activity occurred at another time, the "Poorest Care" was marked.

With the audit as well as the observations, each patient and chart was accounted for by a system of code numbers. The key to the code was destroyed at the completion of the data collection.

Data Analysis

To test the hypothesis, Pearson's Product Moment Correlation Coefficient was calculated. The descriptive statistics used were measures of central tendency and dispersion.

CHAPTER III

RESULTS

Qualpacs

Qualpacs consists of a total of 68 items divided into six major areas: Psychosocial-individual; psychosocial-group; physical; general; communication; and professional implications. A score was derived for each item, a mean for each area, and a grand mean for all 68 items. There was a range of 2.07 with the high score at 4.70 and a low of 2.63. The mean of all the grand means was 3.33. The overall area scores are summarized in Table 4.

There was a total of 30 valid cases for each area with the exception of the psychosocial-group (PSG). This area dealt with nurse/patient interactions which occurred within the context of a group. This was applicable only when a group context such as family, support group, or a group of patients occurred. Many of the patients observed were in private rooms or a double room where there was only one occupant. Often the family was not present. Therefore, group interactions occurred in only approximately half of the observations.

The measures of central tendency reveal a very strong "average" care in each of the six areas. Furthermore, relatively little deviation from the mean is revealed by the measures of variability. The maximum variability occurs in Area V--Communication with a low of 2.00 and a high of 5.00.

A number of items received no ratings at all. They were omitted from the statistical analysis so as to avoid skewing the data by the

Table 4

Area Scores and Grand Mean

Area	No. Valid Cases	Median	Mean	Standard Deviation	Range	Minimum Score	Maximum Score
I (PSI)	30	3.12	3.27	.41	1.86	2.54	4.40
II (PSG)	16	3.02	3.46	.69	2.00	3.00	5.00
III (PHYS)	30	3.14	3.35	.60	2.60	2.40	5.00
IV (GEN)	30	3.09	3.30	.55	2.30	2.60	4.90
V (COMM)	30	3.01	3.28	.69	3.00	2.00	5.00
VI (PROF)	30	3.42	3.53	.56	2.40	2.60	5.00
Grand Mean	30	3.21	3.33	.49	2.07	2.63	4.70

entry of seven 0.00 scores. They were:

Item 9 Patient receives attention for his spiritual needs.

10 The rejecting or demanding patient continues to receive acceptance.

15 The unconscious or non-oriented patient is cared for with the same respectful manner as the conscious patient.

17 The patient receives the help necessary to accept limits on his behavior that are essential to group welfare.

18 The patient receives encouragement to participate in or to plan for the group's daily activities.

19 The member of the group is provided with the opportunity to assume responsibility according to his capability.

21 The patient is helped to vent his emotions in a socially acceptable way within the group.

Of these, 17, 18, 19 and 21 belong to the PSG and so did not occur. Item 10 and 15 were not applicable as unconscious or confused patients were never selected for observation and none of the patients selected were judged to be rejecting or demanding by the raters. Number nine did not occur during the observations, but the need was not identified either and so was judged "not applicable"in all the subjects.

Most of the item means also fell in the "average" category. There were a few exceptions on either side of this average. On the low side, with a score of 2.75, was item 32 which reads:

Behavioral and physiological changes due to medications are observed and appropriate action taken.

On the high side with mean scores of 4.00 were items:

12 The healthy aspects of the patient's personality are utilized.

33 Expectations of patient's behavior are adjusted and acted upon according to the effect the medication has on the patient.

67 Care given patient reflects flexibility in rules and regulations as indicated by individual patient needs.

Audit

The range of scores for all items in the records audit was 0 to 2. There were 30 valid cases for each item. The score "2", which indicated the item was used 100% of the time, was the most frequently occurring score in every item with two exceptions:

1 The nursing assessment has been completed.

21 Flow sheets are completed each day.

Each of these received the score of "1" which meant the item was used, but not always.

All of the item means fell between 1.33 and 1.80--a range of only .47. This reveals very good use of the POR/ND system by the nursing staff most of the time with relatively little variation below the mean.

The mean total score for all the audits was 38.0; the median was 43.3; and the mode was 44.0. There was a standard deviation of 13.52. There were only two extremely low scores. Both of these were due to the use of summary charting rather than POR/ND and the absence of a nursing care plan. In both instances, the patient had been admitted to the unit within the previous 24 hours. This is an area in which there could be some improvement. Another area relates to the two items in the audit that most often received a score of"1". These were items 1, dealing with the completion of the nursing assessment, and 21 which assessed the completion of the flow sheets for each day.

Analysis of Statistical Correlations

Table 5 shows the intercorrelations among all the variables. All of the scores under "AUDIT" related to the hypothesis. The correlation between the Qualpacs observations (TOTAL) and the records audit was positive, but was not statistically significant. Therefore, the hypothesis was not supported by the data.

The correlations between the area scores from Qualpacs and the audit resulted in one significant score. That was between the Communication scale and the audit. The other five areas were in the desired direction, but were not significant.

Table 5

Pearson Correlation Coefficients

	PSG[a]	PHYS	GEN	COMM	PROF	TOTAL	AUDIT
PSI_a	.7276*	.8137*	.8373*	.6194*	.7988*	.8972*	.2107
PSG^a		.7482*	.7872*	.7743*	.7085*	.7996*	.2041
PHYS			.9525*	.7084*	.8378*	.9674*	.0267
GEN				.7334*	.8575*	.9724*	.0789
COMM					.7056*	.7860*	.4788**
PROF						.9068*	.1919
TOTAL							.1465

N = 30

[a]N for PSG = 16

*$P \leq .001$

**$P \leq .01$

CHAPTER IV

DISCUSSION

Theoretical Considerations

It was hypothesized that there would be a positive relationship between the quality of care received by patients as measured by a combination direct/indirect observation method (Qualpacs) and the quality of records using problem-oriented charting and nursing diagnoses. The quality of care for each of 30 patients was established as was the quality of their records. Statistical analysis of these two sets of scores did reveal a correlation in the positive direction, but it was not statistically significant. Therefore, the hypothesis was rejected.

Most of the literature on POR and ND contends that there is a positive relationship between these two variables and the quality of nursing care. It suggests that this relationship occurs as patient problems are identified, recorded in diagnostic terminology, communicated to all of the relevant health care team, addressed, and evaluated. The nursing diagnosis component of the system provides a clear, concise nomenclature for communication of identified problems. The POR provides for a simple, accurate, logical, ordered method for structuring information relevant to the patient. As patient problems and data are organized in this fashion, communication among the health care team should improve (Hurst, 1971); the care received by the patients should improve in terms of thoroughness, efficiency, reliability, and ability of providers to analyze and identify problems; and the data should become more retrievable

for evaluation purposes. Therefore, the combined use of POR and ND was predicted to result in improved quality of care.

The results of this study, however, did not support the literature. There are a number of reasons why this may have happened.

The first, and most obvious possibility, is that there really is no relationship between the use of POR/ND and the quality of care. Goldfinger (1973) maintains that clinical judgment of the users of the system is far more likely to affect quality of care than the particular record system. Feinstein (1973) agrees stating that many of the apparent advantages of the POR arise from the enthusiasm and supervision with which the system is applied rather than from the problem-oriented format. Both of these criticisms of the POR, however, focus on the record element of the system. They do not approach it within the context of the whole philosophy--which leads to a more likely, though less obvious, reason why this particular study did not support the hypothesis.

The system which has been implemented at the study hospital involves only the nursing staff. The other disciplines involved in patient care do not use it. This fact undermines the whole cyclical concept behind the system. It also destroys most of the system's usefulness as a philosophy of patient care. It was noted earlier that it is the system in its entirety that is proposed to elevate the quality of care (Atwood, 1974; Gane, 1973; Hurst, 1971; Lambert, 1974a, Shaughnessy, 1979).

Another factor, related to the system, which may have affected the outcome of the study is the evaluation component. Evaluation is the feedback mechanism for assessing patient outcomes in relation to the identified problems and treatment. It allows for identification of strengths

and/or weaknesses in patient care. The system has been in use on the study unit for just over a year. It is quite possible that the evaluation component has not yet had time to operate.

The ND component of the system also has some weaknesses which may have contributed to the results of this study. For instance, the use of the 42 Accepted Nursing Diagnoses is mandatory on the Problem List and the Nursing Care Plan. This requirement imposes a very limited nomenclature on an almost infinite variety of patient problems. Such a circumstance may cause nurses to lump many problems under one heading in order to make them "fit" in the system. Closely related to this weakness is the lack of clearly defined signs, symptoms and etiologies to accompany each diagnosis. In the absence of these definitions, it was not possible to assess whether appropriate diagnoses had been selected for each problem or whether all the diagnoses had been identified for each set of signs and symptoms. This particular weakness in the use of ND, however, is not peculiar to the study unit. It is symptomatic of the state of ND in general.

The one positive correlation that resulted from this study was between the subscale "Communication" and the records audit. This finding seems to lend support to the literature which claims that the POR and ND will increase communication between the members of the health care team (Hurst, 1971; Mitchell, 1973; Thompson, 1974). It should be noted, however, that the "Communication" subscale in Qualpacs uses not only direct observation to assess this area, but also indirect observations--i.e. the record. Several of the items are rated according to their appearance in the record. This fact necessarily biases the score in the positive direction. Therefore, this correlation holds little meaning.

Methodological Considerations

An examination of the Grand Means reveals that 22 of the 30 scores fell in the 3.0-3.9 range. Of the remaining eight scores, four were slightly below 3.00, and four were above. Most of the scores, then, fell in the "Average" range which indicates that most of the care delivered was of the quality expected from a first level staff nurse--safe, adequate, therapeutic, and supportive. There was relatively little variation.

The Grand Totals from the records audit follow a similar pattern. Of the 30 scores, 24 of them fall in the 40-47 range. The remaining six are all below that level. This resulted in relatively little variation as well.

This lack of variation considerably hampers the usefulness of the data in reference to the hypothesis. The reason for this is that a correlation was being sought between high quality of care scores and high audit scores, and vice versa for scores at the low end of the spectrum. With so many of the scores clustering around the mean, such correlations did not appear often enough to be significant. This may indicate that Qualpacs does not discriminate sufficiently between poor and best care and the records audit was not sufficiently sensitive to the quality of the record system.

Another characteristic of Qualpacs which may have affected the outcome of this study is that it is a process measure. It was noted earlier that of the three frameworks available for measuring quality of care (structure, process, and outcome), outcome would probably be ideal. This type of measure was not used, however, because the focus of this study

was nursing and it is not possible yet to factor out which outcomes are due to nursing and which are produced by other disciplines (Stevens, 1979). This choice to deal only with nursing care was in itself a limitation to the study. It is possible that the positive relationship between the POR/ND and quality of care does exist, but that it is demonstrated in the outcome of patient care rather than the process.

Finally, this was a descriptive correlational study. One of the characteristics of such a study is that in the absence of a control group the investigator has no control over the independent variables. This leaves a rather large question unaddressed in this study and that is, what other variables were operating that may have affected the relationship between POR/ND and the quality of care? The answer to that can only lie in further research.

CHAPTER V

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Summary

This descriptive correlational study was conducted to contribute to the evaluation of the relationship between the use of problem-oriented records in combination with nursing diagnoses and the nursing care received by patients. It was built upon a large body of literature which claims that the use of the POR system and ND will improve the quality of care received by patients.

Two instruments were used to examine the relationship between quality of care and the quality of records using POR/ND. The Quality of Patient Care Scale (Qualpacs) was used to measure quality of care, and a records audit was used to measure the extent to which the POR/ND was being used. A pilot study was done to establish interrater agreement between the two nurse-raters on both instruments. A total of 30 observations and audits were conducted over a period of four weeks on patients randomly selected from the population on the study unit. There was no significant relationship between quality of care and quality of records.

There are a number of theoretical and methodological considerations which may have affected the results of this research. Among these are deficits in the POR system on the study unit, weaknesses in the ND component of the system, the relatively short time lapse since the introduction of POR/ND to the unit, the lack of variability in scores, and the use of a process measure for quality of care.

Conclusion

The conclusion from this research was that there was no evidence of a positive relationship between the use of POR/ND and the quality of nursing care. This was contradictory to most of the literature on the subject and to the small amount of research which has been done in this area.

Recommendations

The following recommendations for further research fall into two categories. The first identifies areas of interest related to the use of POR/ND.

1) What is the staff's perception of the system's utility?
2) Is communication between disciplines improved?
3) To what extent does the nursing diagnosis taxonomy adequately describe patient problems?
4) To what extent do nurses focus on problems amenable to nursing care, independent of medical diagnoses and treatment?

The second relates to the focus of this study--the relationship between POR/ND and quality of nursing care.

1) Replication of this study using a control group.
2) Replication of this study in a setting where the POR/ND system is well established.
3) Replication of this study using outcome measures or a combination of outcome, process and structural measures.
4) Development of a more sensitive tool for testing the use of the POR/ND system.

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APPENDIX A

Quality Patient Care Scale

WAYNE STATE UNIVERSITY

Page 1 of 11 pages

College of Nursing

Date _____

QUALITY PATIENT CARE SCALE

QualPaCS

Patient being rated: _____ Rater (name or No.): _____

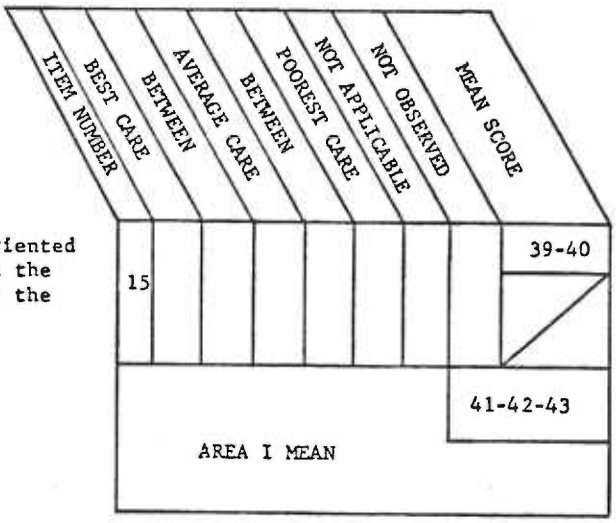
PSYCHO-SOCIAL: INDIVIDUAL

Actions directed toward meeting psycho-social needs of individual patients.

	ITEM NUMBER	BEST CARE	BETWEEN	AVERAGE CARE	BETWEEN	POOREST CARE	NOT APPLICABLE	NOT OBSERVED	MEAN SCORE
1. Patient receives nurse's full attention. # D	1								11-12
2. Patient is given an opportunity to explain his feelings. # D	2								13-14
3. Patient is approached in a kind, gentle, and friendly manner. # D	3								15-16
4. Patient's inappropriate behavior is responded to in a therapeutic manner. # D	4								17-18
5. Appropriate action is taken in response to anticipated or manifest patient anxiety or distress. # D/*I	5								I9-20
6. Patient receives explanation and verbal reassurance when needed. # D	6								21-22
7. Patient receives attention from nurse with neither becoming involved in a non-therapeutic way. # D	7								23-24

QualPaCS

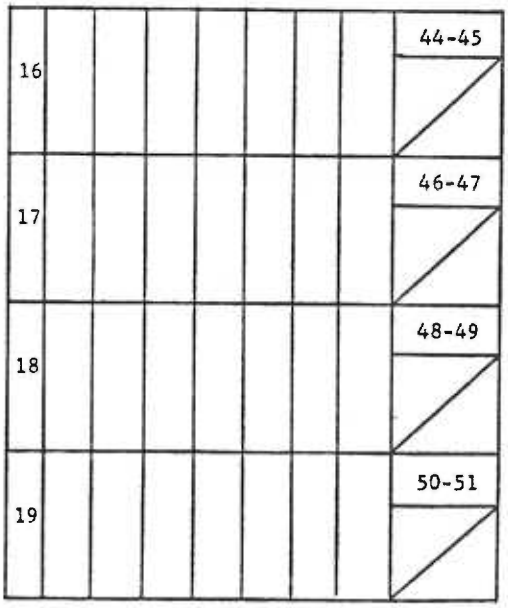
ITEM NUMBER	BEST CARE	BETWEEN	AVERAGE CARE	BETWEEN	POOREST CARE	NOT APPLICABLE	NOT OBSERVED	MEAN SCORE	
8. The patient is given consideration as a member of a family and society. # D/*I									25-26
9. Patient receives attention for his spiritual needs. # D/*I									27-28
10. The rejecting or demanding patient continues to receive acceptance. # D/*I									29-30
11. Patient receives care that communicates worth and dignity of man. # D									31-32
12. The healthy aspects of the patient's personality are utilized. # D/*I									33-34
13. An atmosphere of trust, acceptance, and respect is created rather than one of power, prestige, and authority. # D									35-36
14. Appropriate topics for conversation are chosen. # D									37-38



15. The unconscious or non-oriented patient is cared for with the same respectful manner as the conscious patient. # D

PSYCHO-SOCIAL: GROUP

Actions directed toward meeting psycho-social needs of patients as members of a group.



16. The patient as a member of a group receives warmth, interest, and attention from the staff. # D

17. The patient receives the help necessary to accept limits on his behavior that are essential to group welfare. # D

18. The patient receives encouragement to participate in or to plan for the group's daily activities. # D

19. The member of the group is provided with the opportunity to assume responsibility according to his capability. # D

ITEM NUMBER	BEST CARE	BETWEEN	AVERAGE CARE	BETWEEN	POOREST CARE	NOT APPLICABLE	NOT OBSERVED	MEAN SCORE
20. Staff proposals for patient activities appropriately reflect the interests and needs of the group members. # D	20							52-53
21. The patient is helped to vent his emotions in a socially acceptable way within the group. # D	21							54-55
22. Praise and recognition is given for achievement according to individual needs and with respect for others in the group. # D	22							56-57
23. The rights and integrity of the group member are protected within the group structure. # D	23							58-59
								60-61-62
								AREA II MEAN

PHYSICAL

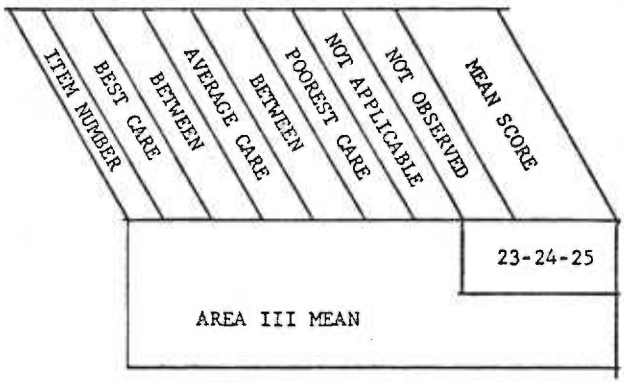
Actions directed toward meeting physical needs of patients.

24. Nursing procedures are adapted to meet needs of individual patients for treatment. # D	24							63-64

QualPaCS

	ITEM NUMBER	BEST CARE	BETWEEN	AVERAGE CARE	BETWEEN	POOREST CARE	NOT APPLICABLE	NOT OBSERVED	MEAN SCORE
25. Patient's daily hygiene needs for cleanliness and acceptable appearance are met. # D	25								65-66
26. Nursing procedures are utilized as media for communication and interaction with patients. # D	26								67-68
27. Physical symptoms and physical changes are identified and appropriate action taken. # D	27								69-70
28. Physical distress evidenced by the patient is responded to quickly and appropriately. # D	28								71-72
29. Patient is encouraged to observe appropriate rest and exercise. # D/*I	29								73-74
30. Patient is encouraged to take adequate diet. # D/*I	30								75-76
31. Action is taken to meet the patient's needs for adequate hydration and elimination. # D/*I	31								77-78

ITEM NUMBER	BEST CARE	BETWEEN	AVERAGE CARE	BETWEEN	POOREST CARE	NOT APPLICABLE	NOT OBSERVED	MEAN SCORE
32. Behavioral and physiological changes due to medications are observed and appropriate action taken. # D/*I	32							79-80
33. Expectations of patient's behavior are adjusted and acted upon according to the effect the medication has on the patient. # D/*I	33							11-12
34. Medical asepsis is carried out in relation to patient's personal hygiene and immediate environment. # D	34							13-14
35. Medical and surgical asepsis is carried out during treatments and special procedures. # D/*I	35							15-16
36. Environment is maintained that gives the patient a feeling of being safe and secure. # D	36							17-18
37. Safety measures are carried out to prevent patient from harming himself or others. # D	37							19-20
38. The established techniques for safe administration of medications and parenteral fluids are carried out. # D	38							21-22



GENERAL

Actions that may be directed toward meeting either psychosocial or physical needs of patient or both at once.

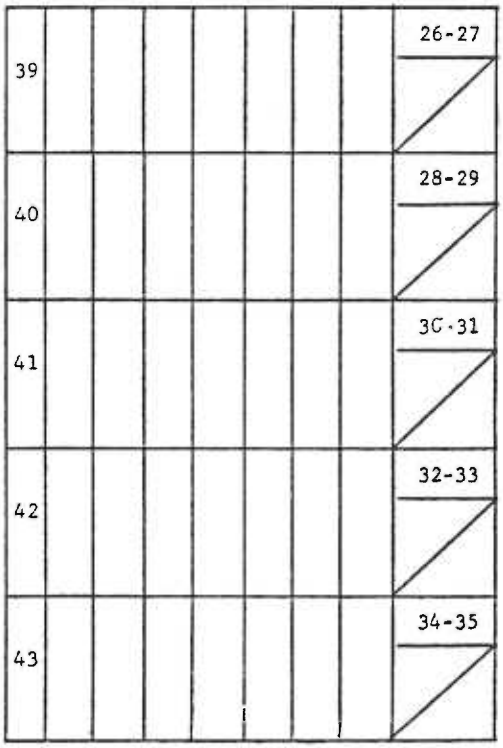
39. Patient receives instruction when necessary. # D

40. The patient and family are involved in planning for care and treatment. # D/*I

41. The patient's sensitivities and right to privacy are protected. # D

42. Patient is helped to accept dependence/independence as appropriate to his condition. # D

43. Resources within the milieu are utilized to provide the patient with opportunities for problem solving. # D

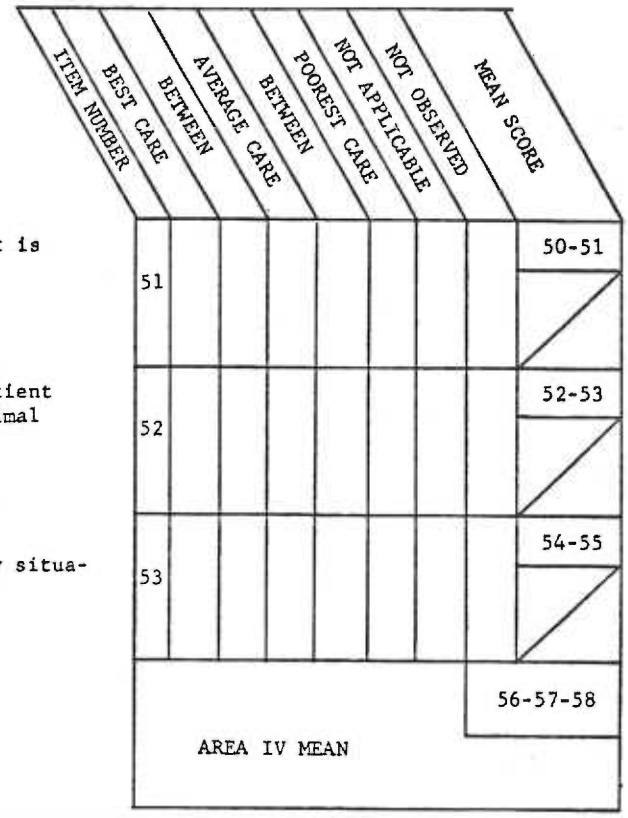


ITEM NUMBER	BEST CARE	BETWEEN	AVERAGE CARE	BETWEEN	POOREST CARE	NOT APPLICABLE	NOT OBSERVED	MEAN SCORE
44. Patient is given freedom of choice in activities of daily living whenever possible and within patient's ability to make the choice. # D	44							36-37
45. Patient is encouraged to take part in activities of daily living that will stimulate his potential for positive psychosocial growth and movement toward physical independence. # D/*I	45							38-39
46. Activities are adapted to physical physical and mental capabilities of patient. # D/*I	46							40-41
47. Nursing care is adapted to patient's level and pace of development. # D	47							42-43
48. Diversional and/or treatment are made available to patient according to his capabilities and needs. # D	48							44-45
49. Patients with slow or unskilled performance are accepted and encouraged. # D	49							46-47
50. Nursing care goals are established and activities performed which recognize and support the therapist's plan of care. # D/*I	50							48-49

51. Interaction with patient is within framework of the therapeutic plan. # D

52. Close observation of patient is carried out with minimal disturbance. # D

53. Response to patient is appropriate in emergency situations. # D

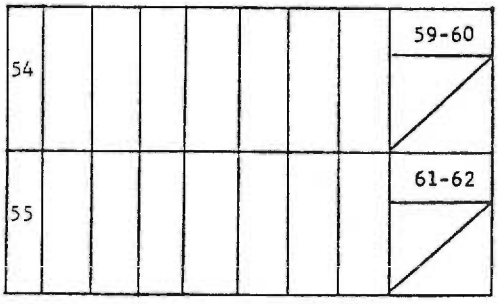


COMMUNICATION

Communication on behalf of patients

54. Ideas, facts, feelings, and concepts about the patient are communicated clearly in speech to medical and paramedical personnel. # D

55. The family is provided with the opportunity for reciprocal communication with the nursing staff. # D/*I



ITEM NUMBER	BEST CARE	BETWEEN	AVERAGE CARE	BETWEEN	POOREST CARE	NOT APPLICABLE	NOT OBSERVED	MEAN SCORE
56. Ideas, facts and concepts about the patient are clearly communicated in charting. *I								63-64
57. Well developed nursing care plans are established and incorporated into nursing assignments. *I								65-66
58. Pertinent incidents of patient's behavior during interaction with staff are accurately reported. # D/*I								67-68
59. Staff participate in conferences concerning patient care. # D								69-70
60. Effective communication and good relationships with other disciplines within the hospital are established for the patient's benefit. # D/*I								71-72
61. Patient's needs are met through the use of referrals, both to departments in the hospital and to other community agencies. # D/*I								73-74
								75-76-77
AREA V MEAN								

PROFESSIONAL IMPLICATIONS

Care given to patients reflects initiative and responsibility indicative of professional expectations.

ITEM NUMBER	BEST CARE	BETWEEN	AVERAGE CARE	BETWEEN	POOREST CARE	NOT APPLICABLE	NOT OBSERVED	MEAN SCORE
62. Decisions that are made by staff reflect knowledge of facts and good judgment. # D/*I								78-79
63. Evidence, (spoken, behavioral, recorded) is given by staff of insight into deeper problems and needs of patients. # D/*I								11-12
64. Changes in care and care plans reflect continuous evaluation of results of nursing care. # D/*I								13-14
65. Staff are reliable: Follow through with responsibilities for patient's care. # D/*I								15-16
66. Assigned staff keep informed of patient's condition and whereabouts. # D								17-18
67. Care given patient reflects flexibility in rules and regulations as indicated by individual patient needs. # D/*I								19-20
68. Organization and management of nursing activities reflect due consideration for patient needs. # D/*I								21-22
AREA VI MEAN								23-24-25
MEAN of MEANS								26-27-28

APPENDIX B

Cues for Quality Patient Care Scale

CUES FOR
QUALITY OF PATIENT CARE SCALE

PSYCHO-SOCIAL: INDIVIDUAL
Actions directed toward meeting psycho-social needs of individual patients.

1. PATIENT RECEIVES NURSE'S FULL ATTENTION. #D
   a. Patient is appropriately responded to, verbally and non-verbally, without being asked to repeat phrases.
   b. Staff assume positions that will aid in observation and communication with patient.
   c. Conversation of staff is restricted to patient who is receiving care.
   d. The infant is looked at and talked to as he receives a bottle feeding.
   e. Questions are posed which encourage patient to express feelings.
   f. Evidence is given by staff of anticipation of projected needs of patient.

2. PATIENT IS GIVEN AN OPPORTUNITY TO EXPLAIN HIS FEELINGS. #D
   a. Facial expression of staff indicates interest in and understanding of patient.
   b. Patient is given time to talk.
   c. Patient is allowed to complete sentence before staff speak or move away from patient.
   d. Conversation is encouraged by staff using brief comments or leading questions to let patient know they are listening and interested.
   e. Conversation is terminated in a manner that patient understands reason for termination, leaving patient with feeling of satisfaction about discussion. (patients facial expression indicates this satisfaction)

3. PATIENT IS APPROACHED IN A KIND, GENTLE, AND FRIENDLY MANNER. # D
   a. Staff speak clearly, with soft and pleasant tone of voice.
   b. Patient is called by name, and informed of name of nurse through distinct enunciation.
   c. Crying patients (all ages) are shown patience and understanding (verbally and nonverbally).

d. Patients are approached with a smile and encouraging word.

e. Patient is given opportunity to initiate verbalization of needs.

4. PATIENT'S INAPPROPRIATE BEHAVIOR IS RESPONDED TO IN A THERAPEUTIC MANNER. # D
   a. Withdrawn patient is assisted to consider various means for involvement or interactions with others.
   b. Attention of adolescent who is teasing others and interfering with activities of others is redirected.
   c. Patient who refuses examination or treatment is helped to think through various facets and alternatives in the situation.
   d. Expressions of hostility are accepted and changes that can be made are made, explanations of why some things cannot be changed are given, and indications are given to the patient that the nurse is interested in knowing the patient's feelings.
   e. Staff communicates, in acceptable manner, dislike of abusive or provoking language or behavior.

5. APPROPRIATE ACTION IS TAKEN IN RESPONSE TO ANTICIPATED OR MANIFEST PATIENT ANXIETY OR DISTRESS. # D/*I
   a. Leading questions are asked to determine what the patient knows about pending therapy and to allow him to express fears.
   b. The laboring mother is encouraged to express her thoughts and feeling about impending delivery, her own safety, and the health of her baby.
   c. Time is spent with the patient or arrangements are made to have someone stay with anxious patient.
   d. Physical indicators of anxiety and distress are noted, such as wringing of hands, disphoresis, withdrawal, etc.
   e. Patient's repeated reference to a topic is noted, and he is encouraged to discuss it.

6. PATIENT RECEIVES EXPLANATION AND VERBAL REASSURANCE WHEN NEEDED. # D/*I
   a. Components and purpose of treatments or nursing care action are explained as appropriate.
   b. Attempts are made to describe kind of pain or discomfort patient may anticipate; including estimate of duration of discomfort and what will be done and what patient might do to alleviate pain or distress.
   c. Patient is helped to explore and understand why he feels about or behaves as he does toward other persons, toward himself, or toward his illness.

d. Comments are made about patient's actions to remind and reassure him of signs of movement toward wellness.

e. Patient is informed of when staff will leave and when they will return.

7. PATIENT RECEIVES ATTENTION FROM NURSE WITH NEITHER BECOMING INVOLVED IN A NON-THERAPEUTIC WAY. # D

a. Nurse-patient relationship is maintained by focusing on patient's interests.

b. Child's needs for affection and closeness are provided for, but child is helped to remember parents and siblings.

c. Appropriate names of address are utilized by both nurse and patient rather than inappropriate endearing terms.

d. Monopoly of time of either patient or nurse is avoided.

e. Patient considering alternate actions is listened to and encouraged, but allowed to make own decision; staff is neither authoritarian nor patronizing.

8. THE PATIENT IS GIVEN CONSIDERATION AS A MEMBER OF FAMILY. # D/*I

a. Care and treatment activities are provided at times that will least interfere with visiting family or friends.

b. Family is encouraged to participate in care of patient, mother encouraged to feed child.

c. Patient is assisted to maintain communication with friends and colleagues — comfortable setting for visitors, assistance with telephoning, positioning and materials for letter writing, prompt mail delivery.

d. Rules are adjusted to meet special needs of patient or family e.g. underage child allowed to visit parent.

9. PATIENT RECEIVES ATTENTION FOR HIS SPIRITUAL NEEDS. # D/*I

a. Patient's religious beliefs and practices are respected.

b. Religious articles are handled with respect.

c. Pastor is promptly called when patient expresses desire to see him, or nurse volunteers to call pastor.

d. Assistance is offered and patient encouraged to attend services of his faith that are available to him (within the realm of his physical ability to go to them).

10. THE REJECTING OR DEMANDING PATIENT CONTINUES TO RECEIVE ACCEPTANCE. # D/*I
    a. Patient who refuses to talk is visited frequently by nurse who displays interested manner and gives assurance of "being there."
    b. Willingness to understand patient's point of view is displayed in relation to refused activity or treatment.
    c. Patient who turns away or shouts, "Go away," is remained with, spoken to quietly and reassuringly, and helped with resolution of need to reject attention offered.
    d. Attempts are made to help patient clarify his understanding of rationale for nurse actions or for treatments she proposes.
    e. Call light is answered promptly and without hostility, despite frequency of demands.

11. PATIENT RECEIVES CARE THAT COMMUNICATES WORTH AND DIGNITY OF MAN. #D
    a. Patient is cared for with kindness and helpfulness.
    b. Patient is encouraged to make choices about daily care and allowed time to make decision and to respond.
    c. Requests and needs of hopelessly ill or dying patient are met with same display of interest as that shown other patients.
    d. Means and opportunities for communication are provided and utilized with patient with communication limitations--speech loss or defect, deafness, limited language skills.
    e. Physical movement of patient is handled so that minimal strain is inflicted on patient.
    f. Patient with permanent body defect is cared for the same as other patients.

12. THE HEALTHY ASPECTS OF THE PATIENT'S PERSONALITY ARE UTILIZED. #D/*I
    a. Patient receives guidance in resolving a problem to decrease frustration of indecision.
    b. Opportunities are provided for patient to receive satisfaction through contributing to others; e.g., having child in wheelchair take toy to child confined to bed.
    c. Patient's abilities are pointed out, while avoiding focus on his disabilities.
    d. Ways are provided and the patient encouraged to enlarge his knowledge in areas that are of interest to him.
    e. The patient's sense of humor is responded to in an appropriate manner.
    f. Conversation is directed into optimistic vein; dwelling on pessimistic outlook is subtly curbed.

13. AN ATMOSPHERE OF TRUST, ACCEPTANCE, AND RESPECT IS CREATED RATHER THAN ONE OF POWER, PRESTIGE, AND AUTHORITY. #D
    a. The patient is trusted in as many ways as possible; he is allowed to perform those care activities within his capacity.
    b. Patient is allowed to express his opinions, and respect for his opinions is reflected in plans and activities of care.
    c. Withholding ordered treatment or necessary care is not used to solicit patient cooperation.
    d. Patient's conversation or activities are not needlessly disrupted.
    e. Inappropriate comments or actions made by the patient are quietly and briefly pointed out to him.

14. APPROPRIATE TOPICS FOR CONVERSATION ARE CHOSEN. #D
    a. Topics of known interest to patient are introduced: particular sport, hobby, TV show, doll, or neighborhood activity.
    b. Patient is encouraged to talk about personal interests and concerns; e.g., children, family, and what family is probably doing at home.
    c. Conversation is guided to neutral or positive subject, if argument develops or seems to be developing.
    d. Discussions realistic to planning for and feelings about the future are encouraged, whether expectation be complete recovery, living with limitations, or death.

15. THE UNCONSCIOUS OR NON-ORIENTED PATIENT IS CARED FOR WITH THE SAME RESPECTFUL MANNER AS THE CONSCIOUS PATIENT. #D
    (Note: Applies as well to lethargic, sedated, or non-verbal patient.)
    a. Assistance is sought in moving the patient and moving is performed in a safe, gentle manner.
    b. Conversation of staff is focused on matters about the patient and his immediate care; jocularity is avoided.
    c. Patient is referred to by name, is spoken to in a well-modulated tone, discussion of patient's condition or prognosis is avoided in patient's presence.
    d. Disoriented patients are informed about anticipated treatments, instructions are offered about what will be expected of him, an attitude of interest in helping the patient to understand is portrayed.
    e. For the patient anticipating anesthesia or other induced unconsciousness, anxiety regarding being unconscious is recognized and discussed. Patient is given support regarding confidentiality of his behavior and conversation during period of unconsciousness.

PSYCHO-SOCIAL: GROUP

Care received reflects recognition of the patient's psycho-social needs as a member of a group.

16. THE PATIENT AS A MEMBER OF A GROUP RECEIVES WARMTH, INTEREST, AND ATTENTION FROM THE STAFF. # D
    a. Conversation of group members are listened to and comments made that promote continuation of patient's interests.
    b. Each member of the group is recognized and acknowledged by the staff.
    c. Patients receive appropriate information about changes in group structure, e.g., one of the ward patients is to remain in I.C.U. overnight following surgery.
    d. New patients are introduced to the group by the staff.
    e. When more than one staff is working with patient, the patient is given recognition as a part of that group.

17. THE PATIENT RECEIVES THE HELP NECESSARY TO ACCEPT LIMITS ON HIS BEHAVIOR THAT ARE ESSENTIAL TO GROUP WELFARE. # D
    a. Reasons for limitations that relate to "regulations" are identified, i.e., no smoking with O_2 in the room.
    b. Group member receives the necessary explanation and guidance regarding group aims.
    c. Groups of adolescents are helped to plan games that permit participation of few with physical limitations, without placing undue attention on individuals with the limitations.
    d. Hostile expressions relating to limits are accepted, but staff remains firm and consistent in maintaining necessary limits.
    e. Reason for exclusion of an individual from a group is explained without embarrassment for either the individual or group.

18. THE PATIENT RECEIVES ENCOURAGEMENT TO PARTICIPATE IN OR TO PLAN FOR THE GROUP'S DAILY ACTIVITIES. # D
    a. Patients are assisted with planning activities and time schedules, such as bathroom privileges.
    b. Patients are assisted in planning to help others in the group, e.g., when to take the paralyzed patient to the sunporch in a wheelchair.
    c. Patients' suggestions and assistance are sought in making changes in physical setting — furniture arrangement, room assignments, etc.

d. Patients are assisted in making arrangements for some social activities, e.g., sharing of meals by three or four patients.

19. THE MEMBER OF THE GROUP IS PROVIDED WITH THE OPPORTUNITY TO ASSUME RESPONSIBILITY ACCORDING TO HIS CAPABILITY. # D
    a. Mother with one or more children is given the opportunity to offer suggestions to "new mothers."
    b. Aggressive patient is encouraged to serve as member of committee providing support to "chairman," but not "take over" chairman's duties.
    c. Patient is provided with schedule for his examinations or treatment and it is suggested that he assume responsibility for being at the right place at the right time.
    d. Patient is allowed to initiate preparations for meals, visits, or bedtime, without being reminded each time that it is time to do these things.
    e. The ambulatory patient is permitted to feed other patients in the room.

20. STAFF PROPOSALS FOR PATIENT ACTIVITIES APPROPRIATELY REFLECT THE INTERESTS AND NEEDS OF THE GROUP MEMBERS. # D
    a. Involvement of each patient in group activities is noted and subtle suggestions given of modifications to insure appropriate involvement of all, such as proposing that the child with the injured knee keep score for the volley ball games.
    b. Ways of dividing group into small common-interest groups are suggested: checkers, pinochle, jig-saw puzzles, playing with dolls, building with blocks, etc.
    c. New diabetic is guided in discussing with others, the disease and its meaning to them.
    d. New mother is encouraged to attend infant bath demonstrations.

21. THE PATIENT IS HELPED TO VENT HIS EMOTIONS IN A SOCIALLY ACCEPTABLE WAY WITHIN THE GROUP. # D
    a. Group is helped to establish guidelines and discussion of emotion-laden issues is encouraged, e.g., that children discuss experiences, and feelings about the school and teachers or that patients "debate" merits of various sides of political issues.
    b. New-mother is given opportunity to discuss her fears and hopes with other mothers, staff, other parents.
    c. Hostility is recognized and activities offered that demand physical strengths, energy and movement; e.g., a round or two with punching bag, volleyball, or dodgeball.

d. Group who is confined in the hospital for long periods of time (e.g. TB patients) are guided in discussing their feelings about isolation and restriction of physical activity, and helped to devise activities appropriate to the limits imposed, e.g., developing a patient-government.

e. Patients who have suffered a change in body image (amputation of lower limb, colostomy, mastectomy) are allowed to grieve without being forced to participate in activities before they are ready.

22. PRAISE AND RECOGNITION IS GIVEN FOR ACHIEVEMENT ACCORDING TO INDIVIDUAL NEEDS AND WITH RESPECT FOR OTHERS IN THE GROUP. # D

a. Staff moves quickly to next activity, when "braggart" has scored point — patient is helped to recognize his accomplishment in relation to his abilities and those of others; he is guided to recognize achievements of others.

b. Staff discuss and help patient recognize relationship of small accomplishment to potential for "next (more difficult) step;" e.g., patient able to hold self up off bed for 30 seconds in preparation for crutch walking, mastectomy patient able to raise affected arm above head.

c. Child is praised for his control during an examination.

23. THE RIGHTS AND INTEGRITY OF THE GROUP MEMBER ARE PROTECTED WITHIN THE GROUP STRUCTURE. # D

a. Conversations about death are changed by staff if one of the members is displaying anxiety.

b. The group members or patients are informed of the problems of the aphasic patient, e.g., he can understand conversation but cannot contribute verbally.

c. The patient who is unable to eat without drooling is given assistance with feeding.

d. Hesitant patients are encouraged to join activity; less apt patients are assisted without the performance actually being done for them.

e. Provision is made for maintaining confidentiality when personal matters of the patient are involved.

PHYSICAL: ACTIONS DIRECTED TOWARD MEETING PHYSICAL NEEDS OF PATIENTS.

24. NURSING PROCEDURES ARE ADAPTED TO MEET NEEDS OF INDIVID PATIENTS FOR TREATMENT. # D
    a. Sufficient time is allowed following patient's smoking, eating or drinking in taking an oral temperature.
    b. Equipment and materials are arranged on side of bed and in convenient position for left-handed patients to do his own tracheal suction.
    c. General morning care of arthritic patient is left until last so no one will feel pressure of time and movements can be made slowly.
    d. Colostomy irrigation is done at the time the patient states would be most convenient for him at home.

25. PATIENT'S DAILY HYGIENE NEEDS FOR CLEANLINESS AND ACCEPTABLE APPEARANCE ARE MET. # D
    a. Staff offer to comb hair of patient unable to do so for physical or mental reasons; e.g., cardiac patient, patient with upper extremity injury, patient in state of emotional shock following loss of loved ones, regressed mental patient.
    b. Disturbed patient is helped to shower, shave, and select clean clothing or items of attire that go together.
    c. Bedside environment is made neat and orderly, soiled gowns changed P.R.N.
    d. Assistance is offered with oral hygiene; e.g., brush is prepared and basin held for patient with upper extremity cast; dentures brushed under running water for patient unable to do this himself; child is taught proper brushing technique.
    e. Body, dressing, and air deodorizers are provided as indicated.

26. NURSING PROCEDURES ARE UTILIZED AS MEDIA FOR COMMUNICATION AND INTERACTION WITH PATIENTS. # D
    a. Withdrawn patient is encouraged to talk of self, interests, and family, while receiving direct nursing care.
    b. During each contact, staff encourage and allow time for the patient unable to speak (aphasic, tracheotomized, etc.) to write some message; they take time to respond to each message in an unhurried manner.
    c. The periplegic patient is encouraged to discuss his progress in Physiotherapy while the nurse makes his unoccupied bed.
    d. Mother is helped to listen to heartbeat of her unborn child and encouraged to talk about the baby and its meaning to her.
    e. Patient is encouraged to assist, even in a small way, with particularly painful treatment, e.g., burn dressing, repeated intramuscular injection, etc.

27. PHYSICAL SYMPTOMS AND PHYSICAL CHANGES ARE IDENTIFIED AND APPROPRIATE ACTION TAKEN. # D
    a. Cyanosis is noted — staff checks for bleeding, oxygen flow, position in relation to breathing.
    b. Motley tissues over bony prominence are noted; frequency of turning patient is increased and ways provided to keep pressure from area.
    c. Languor and shallow breathing of small child is noted and appropriate action taken.
    d. Undesirable weight loss is noted in elderly clinic patient; patient is questioned about changes in eating habits, living conditions, appetite.
    e. The fundus of the uterus is massaged to evaluate the possibility of postpartum hemorrhage.

28. PHYSICAL DISTRESS EVIDENCED BY THE PATIENT IS RESPONDED TO QUICKLY AND APPROPRIATELY. # D
    a. Patient is moved up in bed and pillows adjusted to provide a comfortable position and good body alignment.
    b. Patient's complaint of pain or burning at site of infusion prompts investigation for infiltration and possible removal of the needle.
    c. Signs of pain are noted — restlessness, perspiration, facial contortion — action is taken to alleviate pain: position changed, medication, fresh dressing.
    d. Excoriated buttocks of baby noted and diapers changed frequently to keep baby clean and dry, and soothing protective ointment or powder applied.
    e. Patient with respiratory tract secretions either is assisted to deep breathe and cough, or is suctioned.

29. PATIENT IS ENCOURAGED TO OBSERVE APPROPRIATE REST AND EXERCISE. # D/*I
    a. Patient is helped to understand role of rest in his treatment — cardiac, thrombophlebitis, hepatitis, chorea.
    b. Patient is helped to understand role of exercise in treatment of his illness — post-surgical, paralysis, traction or cast immobilization.
    c. Elderly patient is assisted out of bed; patient is encouraged to stand and to help self. Patient is given time to do for himself, but necessary assistance and protection is offered.
    d. Patient is helped to plan ways to save movement and steps in accomplishing tasks of daily care.

e. New activities are suggested to patient; reading or light handcrafts for rest; playing pool or ping pong for exercise.

30. PATIENT IS ENCOURAGED TO TAKE ADEQUATE DIET. # D/*I
    a. Eating habits are discussed with patient to learn cultural and social habits as well as food likes and dislikes.
    b. Patient is helped to know what constitutes an adequate diet.
    c. Interest is displayed in attractiveness and appropriateness of patient's trays; assistance is promptly given in making corrections.
    d. Pleasant atmosphere is provided for mealtime, company is provided wherever possible — other patients, volunteers, visitors.
    e. Special dietary needs or increased requirements of certain dietary constituents are discussed and appropriate foods on tray pointed out to patient.

31. ACTION IS TAKEN TO MEET THE PATIENT'S NEED FOR ADEQUATE HYDRATION AND ELIMINATION. # D/*I
    a. Elimination patterns are identified and steps taken to promote adequate elimination, e.g., laxatives, proper diet, exercise.
    b. Patient overanxious about elimination is given opportunities to discuss concerns and is provided information to enhance understanding.
    c. Fluids are encouraged in the dehydrated patient or the patient losing large amounts of fluid, e.g., diaphoresis with elevated temp.
    d. Intake and output is measured accurately, e.g., N/G drainage, Foley catheter, wound drains, postpartal bleeding.
    e. Diarrhea in the infant is reported promptly and measures taken to alleviate the problem.
    f. Measures are initiated to prevent elimination problems or problems of limited intake whenever there is psychomotor retardation as in the depressed patient.

32. BEHAVIORAL AND PHYSIOLOGICAL CHANGES DUE TO MEDICATIONS ARE OBSERVED AND APPROPRIATE ACTION TAKEN. # D/*I
    a. Skin reactions of patients are reported and drug is withheld as necessary.
    b. Disturbances in orientation are recorded and reported.
    c. Anorexia is noted and reported in a patient on a digitalic preparation.

d. Relaxation and amount of sleep obtained in response to sedative is noted and reported.

e. The effect of a mucolytic agent administered during an I.P.P.B. treatment is noted: expectoration, productivity quality of cough.

33. EXPECTATIONS OF PATIENT'S BEHAVIOR ARE ADJUSTED AND ACTED UPON ACCORDING TO THE EFFECT THE MEDICATIONS HAS ON THE PATIENT. # D/*I

a. Drowsiness and retarded psychomotor activity is accepted by supporting the patient when he points out that he is unable to participate in active discussions or sports.

b. For the tremulous patient, projects are selected that require little coordination.

c. Patient who has postural hypotension as a result of drug therapy is allowed to ambulate slowly without pressure to hurry; notation is made in nursing care Kardex.

d. Allows tranquilized or sedated patients ample time to respond to questions.

e. Photo-sensitivity is observed and patient is not expected to participate in outside activities for extended periods of time.

34. MEDICAL ASEPSIS IS CARRIED OUT IN RELATION TO PATIENT'S PERSONAL HYGIENE AND IMMEDIATE ENVIRONMENT. # D

a. Staff wash hands as necessary, e.g., on completing care of one patient and before moving to another, before beginning "clean" procedure, following any obvious contamination, etc.

b. Floor is recognized as grossly contaminated area; e.g., items picked up from floor are cleaned or replaced; hands are washed after picking up something from floor; staff avoid placing supplies or equipment on the floor.

c. In giving a bath, motion proceeds from the clean to the unclean areas.

d. All equipment used by or for patient is clean: tub, sitz bath, I.P.P.B. etc, used by more than one patient are cleansed well between uses; wheelchair, Hoyer lift, and carts for transporting supplies and equipment to patient are clean.

e. Soiled linen and dressings are changed promptly to prevent infection or skin breakdown to the patient.

35. MEDICAL AND SURGICAL ASEPSIS IS CARRIED OUT DURING TREATMENTS AND SPECIAL PROCEDURES. # D/*I

a. Dressings are handled so that surface that will cover wound and surrounding area remains sterile.

b. Site for injection of medication is cleansed properly prior to administration of drug.

c. Irrigations done without contamination.

d. Cross contamination is avoided, e.g., gloves are changed between dressings for each stump of the patient with a bilateral amputation.

e. Breaks in technique are recognized and steps taken to correct them, e.g., contaminated catheter is replaced by sterile catheter, gloves are changed if tear occurs.

f. Staff make appropriate judgment as to when medical or surgical asepsis is called for in Rx.

36. ENVIRONMENT IS MAINTAINED THAT GIVES THE PATIENT A FEELING OF BEING SAFE AND SECURE. # D

a. Assistance of a sufficient number of persons is obtained when a patient is to be lifted.

b. Siderails are provided per request by patient; the necessity for siderails is explained.

c. Placement of various cords and tubing are noted; patients are informed of their presence and, as necessary, instructed about movement.

d. Reasons for "no smoking" signs in presence of oxygen administration are discussed with patient and visitors.

e. Patients' allergies are known and measures taken to prevent exposure to allergies, e.g., feathers, eggs, bleach.

f. Patient is properly secured when on Stryker frame, circle bed, or some type of similar equipment.

37. SAFETY MEASURES ARE CARRIED OUT TO PREVENT PARIENT FROM HARMING HIMSELF OR OTHERS. # D

a. Threats made by patient to harm himself or others are reported and precautions taken as indicated.

b. Patient whose behavior indicated impulsiveness and confusion is protected by the continuous presence of staff or the appropriate use of equipment (siderails and body restraints).

c. Staff ask for assistance when needed to provide safety for the patient himself and/or personnel.

d. Patient is given adequate instructions in use of self-operated particularly powered, equipment (wheelchair, hi-low bed, water temperature controls, etc.) as that he knows safe handling, capabilities and dangers.

38. THE ESTABLISHED TECHNIQUES FOR SAFE ADMINISTRATION OF MEDICATIONS AND PARENTERAL FLUIDS ARE CARRIED OUT. # D
    a. IV and tube feedings with medications added are labeled appropriately.
    b. Those medications left at bedside are properly labeled; they are left only when it is advisable and feasible for the patient to administer to himself and only following adequate instructions to the patient.
    c. Patient is addressed by name or asked to state name, or the identaband or bed tag is checked, before medication is given. Nurse remains with patient until medication is taken.
    d. Medication tray is not left unattended where it could be a danger to one or more patients.
    e. IV flowrate and site are checked to assure appropriate administration.

GENERAL

Actions that may be directed toward meeting either psycho-social or physical needs of patients, or both at once.

39. PATIENT RECEIVES INSTRUCTION WHEN NECESSARY. # D
    a. Mother is guided as she picks up baby, staff demonstrates and has mother demonstrate holding baby for burping and bathing.
    b. Uses of signal cord and intercom are demonstrated to newly admitted patient.
    c. Medications patient will be taking at home are discussed; nurse insures that he knows identity of each, purpose for which it is being prescribed, dosage and schedule for taking each, and expected effects of medication.
    d. Cardiac patient is given examples of how to conserve energy at home, e.g., arrangements of cooking utensils in the kitchen.
    e. Pre and post-operative instruction is provided.

40. THE PATIENT AND FAMILY ARE INVOLVED IN PLANNING FOR CARE AND TREATMENT. *I/# D
    a. When giving instructions to patient, nurse involves family member if he is visiting — not only allowing him to remain in his room, but actually including him in discussion.
    b. Arrangements are made to have family member participate in treatments, eventually doing entire treatment, if it is one patient will not be able to do for himself at home.

c. Plans are made with patient and family members to do care procedures at time when family member can participate; details of care needed at home are planned with patient and family members.

d. Patient is helped to communicate with family about needs for items and procedures of care after discharge — wife to know diet, husband to know of work-saving methods and devices, parents to anticipate teasing of child by other children and ways to help child cope.

41. THE PATIENT'S SENSITIVITIES AND RIGHT TO PRIVACY ARE PROTECTED. # D

a. Sheets or towels are used as drapes to avoid unnecessary exposure of body.

b. Curtain is drawn around bed for procedures of physical care.

c. Arrangements are made to have patient taken to room where interview (social worker, psychologist, homemaker) can be conducted in private.

d. Sensitivities of maturing child and teenager are protected.

e. Dentures are promptly replaced after cleansing or after surgery for patient who is sensitive about being without them.

42. PATIENT IS HELPED TO ACCEPT DEPENDENCE/INDEPENDENCE AS APPROPRIATE TO HIS CONDITION. # D

a. Role of rest in treatment of disease is discussed, patient is reassured of gradual progress toward resumption of responsibility of doing for himself.

b. Patient having surgery is helped to understand the purpose of early ambulation and exercises in the post-operative period, e.g., out-of-bed to bathroom instead of urinal or bedpan.

c. Mother encouraged to hold infant and offer bottle feeding during early postpartal period.

d. Patient with disability of musculoskeletal system is helped to understand disease process, rationale for treatments, and probable outcome.

e. For a patient wishing to continue dependence, the rationale for increasing independence is explained; the staff display empathy and provide support and encouragement as the patient performs required activities for movement toward independence. E.g., a patient (any age), with an upper extremity or chest injury, is supported and encouraged to wash his face, brush his teeth, do his hair, and feed himself.

43. RESOURCES WITHIN THE MILIEU ARE UTILIZED TO PROVIDE THE PATIENT WITH OPPORTUNITIES FOR PROBLEM SOLVING. # D

    a. Patient is encouraged to suggest ways to accomplish "routine" tasks despite limitation due to incapacitated or absent body feature. He is helped to plan placement of articles as he will use them in hospital and at home or work.

    b. Patient is helped to consider alternatives in relation to choice of diversional activity.

    c. Child is helped to select the most appropriate toy for the situation — kind of toy that can be used in bed, one that allows for solitary play, or one that allows others to join in play, etc.

    d. Patients are asked to propose furniture arrangement that will provide for best use of day and artificial lighting and for least distressful light glares.

44. PATIENT IS GIVEN FREEDOM OF CHOICE IN ACTIVITIES OF DAILY LIVING WHENEVER POSSIBLE AND WITHIN PATIENT'S ABILITY TO MAKE THE CHOICE. # D

    a. Determination is made of whether patient is "early" or "late" riser, plans are made with him about timing for needed care.

    b. Patient is allowed morning or evening shower or bath — depending on custom and preference.

    c. Patient is assisted to arrange for type of clothing he prefers to wear, as long as it does not interfere with the therapy.

    d. Requests are granted involving changes in daily routines that can be made without major disruptions in ward plans.

45. PATIENT IS ENCOURAGED TO TAKE PART IN ACTIVITIES OF DAILY LIVING THAT WILL STIMULATE HIM FOR POSITIVE PSYCHOSOCIAL GROWTH AND MOVEMENT TOWARD PHYSICAL INDEPENDENCE. # D/*I

    a. "Early" riser is encouraged to assist with serving morning coffee, where a.m. coffee is a practice.

    b. Stroke patient is encouraged to shave himself — electric razor is provided if indicated.

    c. Patient is invited to assist with caring for flowers — his own and those of others.

    d. Child is helped and encouraged to brush his teeth regularly.

    e. Patient's efforts and successes are recognized.

46. ACTIVITIES ARE ADAPTED TO PHYSICAL AND MENTAL CAPABILITIES OF PATIENT. #D/*I
    a. Hard of hearing patient is provided with an earphone to facilitate listening to his radio or T.V.
    b. Confused patient is guided through steps of preparation for visit to therapist: reminds patients, one step at a time about washing face and hands, brushing teeth, combing hair, dressing, storing night clothing, etc.
    c. Time is allowed for small child, or slow or hesitant patient, to do things for himself, so that he may develop confidence and independence.
    d. Assistance is provided to patient before he reaches point of frustration at inability to perform task.
    e. Long term diabetic patient allowed to administer own insulin while hospitalized.

47. NURSING CARE IS ADAPTED TO PATIENT'S LEVEL AND PACE OF DEVELOPMENT. #D
    a. Child is allowed to perform task of which he is capable; is provided with challenging tasks within his ability to learn and perform them.
    b. "Contests" related to learning new tasks are avoided when patients would experience frustration and feelings of inadequacy.
    c. Instructions and performances of tasks to be learned are repeated as often as necessary.
    d. Patient is assisted to rethink a problem and decide whether to pursue a path different from one selected earlier.
    e. A doll is used to illustrate the care a child scheduled for surgery will receive.

48. DIVERSIONAL AND/OR TREATMENT ACTIVITIES ARE MADE AVAILABLE TO PATIENT ACCORDING TO HIS CAPABILITIES AND NEEDS. #D
    a. Stories are read to a small child.
    b. Rubber ball is provided for stroke patient for hand exercise.
    c. Older patient is taken to dayroom and time spent with him, he is encouraged to visit or share activity--needlework, cards, program on TV.

49. PATIENTS WITH SLOW OR UNSKILLED PERFORMANCE ARE ACCEPTED AND ENCOURAGED. #D
    a. Gentle persuasion is used to keep regressed patient moving in process of morning toilet and dressing.
    b. Time is provided for the aphasic patient to speak.
    c. A child with cerebral palsy is encouraged to learn to feed himself.
    d. A dyspneic patient is provided time "to catch his breath" when moving in bed or ambulating.

50. NURSING CARE GOALS ARE ESTABLISHED AND ACTIVITIES PERFORMED WHICH RECOGNIZE AND SUPPORT THE THERAPIST'S PLAN OF CARE. #D/*I
    a. The arthritic patient received encouragement and direction from the nursing personnel in doing ordered hand exercises.
    b. New mother is assisted with breast feeding, e.g., proper cleansing of breast prior to feeding, proper positioning, etc.
    c. Child's tray is removed after thirty minutes, regardless of amount of food eaten (when purpose is to assist child to establish good eating habits, and to not play with food).
    d. Toileting schedule is planned with paraplegic patient, with view to achieving independence from indwelling catheter.
    e. A patient with a decubitus ulcer is helped to plan a menu high in protein and encouraged to eat.

51. INTERACTION WITH PATIENT IS WITHIN FRAMEWORK OF THE THERAPEUTIC PLAN. #D
    a. A disoriented patient is helped to reorient himself by having reality pointed out to him when confused.
    b. Patient with myocardial infarction is reassured that it is not too much bother to feed him.
    c. A patient learning to use crutches is reassured that the nurse will remain near and will support him if needed, but is encouraged to walk with support of crutches.

52. CLOSE OBSERVATION OF PATIENT IS CARRIED OUT WITH MINIMAL DISTURBANCE. #D
    a. Quiet is maintained as staff move into and out of room for frequent checking: IV, O_2 flow, urine output, etc.
    b. Bed clothing is arranged so that it can easily be lifted to check on extremity.
    c. Staff approach and stand quietly beside group engaged in game or conversation, without interrupting or distracting attention or members of group.
    d. Room of patient with suicidal tendencies is checked during daily cleaning for harmful objects.

53. RESPONSE TO PATIENT IS APPROPRIATE IN EMERGENCY SITUATIONS. # D
    a. Staff wait until help is available to move patient who has fallen from bed.
    b. Patient who has assumed posture to suit his words of threatening to strike nurse is spoken to quietly.
    c. Staff remain with child having asthmatic attack and summon available help.
    d. Staff stay with a convulsing patient for observation and to provide protection from injury.
    e. Intravenous glucose is immediately prepared for the diabetic patient in severe insulin shock.

COMMUNICATION

Communication on behalf of patients.

54. IDEAS, FACTS, FEELINGS, AND CONCEPTS ABOUT THE PATIENT ARE COMMUNICATED CLEARLY IN SPEECH TO MEDICAL AND PARAMEDICAL PERSONNEL. # D
    a. Feelings and thoughts expressed are neither mumbled nor highly emotional.
    b. Complete description of patient's behavior is given without excessive repetition and using good sequence.
    c. Reports of observations are factual and clearly stated leading to meaningful conclusions.
    d. Questions are used to help aides report and describe patient's condition, and to ascertain that aides have understood plan for care.

55. THE FAMILY IS PROVIDED WITH THE OPPORTUNITY FOR RECIPROCAL COMMUNICATION WITH THE NURSING STAFF. # D/*I
    a. Explanations regarding the treatment and therapy that the patient is receiving are stated clearly and in understandable terms.
    b. The fears and concerns of the family are responded to in a manner which promotes an understanding and acceptance of their role in meeting the patient's needs, e.g., Mother stays overnight in room with child who has had a tonsillectomy.
    c. The family is kept informed of changes in the patient's condition, e.g., the expectant father is given frequent reports on his wife's progress during labor.
    d. The family is used as a resource for additional information about the patient to develop a relevant plan of care, e.g., daily activities, occupation, habit patterns, etc.

56. IDEAS, FACTS, AND CONCEPTS ABOUT THE PATIENT ARE CLEARLY COMMUNICATED IN CHARTING. *I
    a. Precise and specific observations are recorded; few generalizing cliches are used (i.e., comatose, disoriented).
    b. Possible interpretation of reasons for patient's behavior is recorded.
    c. Sentence structure is clear and grammatically correct; excessive use of abbreviations is avoided.
    d. All pertinent facts or observations in a situation are included in charting.
    e. Written communication is legible, legal abbreviations only used.

57. WELL DEVELOPED NURSING CARE PLANS ARE ESTABLISHED AND INCORPORATED INTO NURSING ASSIGNMENTS. *I
    a. Immediate and long-range objectives of care are included; changed as patient needs change, also dated.
    b. Information is included about patient's likes and dislikes.
    c. Suggestions for modification of procedures that make care easier or more effective for patient are included.
    d. Plan for implementation of progressive care is included relating to anticipated future needs of patients, e.g., "plan to teach colon irrigation beginning tomorrow."
    e. Written assignments or worksheets reflect the objectives of the plan of care.

58. PERTINENT INCIDENTS OF PATIENT'S BEHAVIOR DURING INTERACTION WITH STAFF ARE ACCURATELY REPORTED. #D/*I
    a. Nurse reports that patient refused to take IM injection, with claim she hurt him last time she gave it.
    b. Nurse reports patient refusal to sit up in chair because patient states he was left up too long yesterday.
    c. Patient's response during or after the interaction with the staff, e.g., Patient withdrew from group discussion after being reprimanded in front of group by nurse for telling a vulgar story.
    d. After instruction for giving self injection, nurse charts patient's response to his initial self injection.

59. STAFF PARTICIPATE IN CONFERENCES CONCERNING PATIENT CARE. # D
    a. Staff volunteer observations they have made, e.g., in team reports.
    b. Pertinent information is given to the staff about a particular patient's disease condition and recommended treatment.
    c. Staff offer proposals of approaches to care of particular patient.
    d. Nurse asks questions that will elicit information or ideas from other workers.

60. EFFECTIVE COMMUNICATION AND GOOD RELATIONSHIPS WITH OTHER DISCIPLINES WITHIN THE HOSPITAL ARE ESTABLISHED FOR THE PATIENT'S BENEFIT. *I/# D
    a. Physical therapist is consulted to seek suggestions of what nursing staff might do to enhance patient's treatment.
    b. Social worker is called for a patient who might benefit from help, e.g., payment of rent while in hospital, care of children during hospital stay.
    c. X-ray or lab is notified promptly to clarify orders for preparation of patient or when patient will be delayed or unable to keep appointment.
    d. Physician is notified of all pertinent information about patient — verbal reports, printed notes on front of chart, paging or telephoning.
    e. Occupational therapy consultation is requested for patient with severly injured hand.

61. PATIENT'S NEEDS ARE MET THROUGH THE USE OF REFERRALS, BOTH TO DEPARTMENTS IN THE HOSPITAL AND TO OTHER COMMUNITY AGENCIES. *I/# D
    a. VNA referral is made for new mother with first baby who is new to city and has no family or friends who can assist with teaching care of new baby.
    b. Social worker is consulted about referral to visiting housekeeper for elderly patient who lives alone.
    c. Local school system is called to arrange for home teaching for adolescent patient.
    d. Adequate information regarding post-discharge clinic appointments is given to the patient, e.g., location of clinic within hospital, time and date of appointment.

F. PROFESSIONAL IMPLICATIONS
Care given to patients reflects initiative and responsibility indicative of professional expectations.

62. DECISIONS THAT ARE MADE BY STAFF REFLECT KNOWLEDGE OF FACTS AND GOOD JUDGMENT. # D/*I

    a. Room assignment of patient whose baby died during delivery is changed to avoid placing her in room with mother with day-old baby.

    b. PRN analgesic and PRN hypnotic are administered at bedtime to second day post-operative patient with spinal fusion.

    c. IV fluid is promptly slowed when post-operative patient manifests increased difficulty and rate of breathing.

    d. Emphysema patient is served six small feedings a day.

    e. Joking references made by patient about "jumping out of window" are responded to with increased periods of observation and by obtaining available information (doctor, chart, etc.) for adequate evaluation of behavior.

    f. Nurse aide seeks help when in doubt.

63. EVIDENCE (SPOKEN, BEHAVIORAL, RECORDED) IS GIVEN BY STAFF OF INSIGHT INTO DEEPER PROBLEMS AND NEEDS OF PATIENTS. # D/*I

    a. Patient who lost first two children at birth is not left alone any more than necessary, and nurses share her experience with her.

    b. Staff attempt to help adolescent with severe acne to recognize and utilize assets and abilities to contribute to interest and happiness of others, thereby gaining confidence and satisfaction in his own worth.

    c. Staff provides support to the dying patient by listening to his fears and by avoiding unrealistic cliches as "you'll be up and around in no time."

    d. Staff discuss possible approaches to be used with patient who has just sustained a change in body image, i.e., hysterectomy, mastectomy, amputation, spinal cord transection, hemiplegia.

64. CHANGES IN CARE AND CARE PLANS REFLECT CONTINUOUS EVALUATION OF RESULTS OF NURSING CARE. *I/# D

    a. Suggestion is made that wound be dressed after wife's visit since changing the patient's dressing before her visit focus's his attention on the wound to the extent that he discusses little else.

    b. Referrals for home visits are made for the amputee patient when it is discovered that his recent return to dependency upon the staff is the result of his fears about his adequacy in the home situation.

c. Passive exercises to the paralyzed hand of the C.V.A. patient have resulted in prevention of contractures and plans are made to continue them.

d. Suggestions or criticisms made by the patient and family are utilized constructively in planning and evaluating care.

e. Change is suggested in types of foods, since patient is not eating present diet and complains that it is "baby" food.

65. STAFF ARE RELIABLE: FOLLOW THROUGH WITH RESPONSIBILITIES FOR PATIENT'S CARE. # D/*I

a. Staff ask for help in doubtful situations, rather than making errors.

b. Staff report when work is not completed.

c. Nurse views situation herself, rather than depending on reports alone; e.g., visits patient on report of bleeding, checks conditions of very ill patients in preparation for change-of-shift report.

d. Assignments and work accomplished are periodically reviewed to replan, establish priorities, and fulfill responsibilities.

e. Staff follows through on commitments they have made; e.g., return to patient's room at time stated, perform treatment when scheduled.

66. ASSIGNED STAFF KEEP INFORMED OF PATIENT'S CONDITION AND WHEREABOUTS. # D

a. All assigned patients are visited to ascertain their condition before day's tasks are begun.

b. Patient's whereabouts are known along with reason for his being off the unit or away from bedside unit, and when he is expected to return.

c. Current condition of patient is known as well as changes in past 24 hours, and plans of care are reported to staff of succeeding tour of duty.

d. If indicated, patient is accompanied by staff when leaving unit for tests or conferences.

67. CARE GIVEN PATIENT REFLECTS FLEXIBILITY IN RULES AND REGULATIONS AS INDICATED BY INDIVIDUAL PATIENT NEEDS. # D/*I

a. Adjustments in visiting hours are made in accord with the patient's condition and the special needs of his family.

b. Room change is provided as soon as possible for non-ambulatory patient who smokes when he is assigned to room where O_2 is in use.

c. Patient who is on a regular diet but not eating well is allowed to have family bring in favorite foods.

d. Patient who has worked on the midnight shift for years and is not able to sleep is allowed to watch late TV or listen to the radio when it will not disturb other patients.

68. ORGANIZATION AND MANAGEMENT OF NURSING ACTIVITIES REFLECT DUE CONSIDERATION FOR PATIENT NEEDS. # D/*I

a. Treatments are performed at times that will not interfere with visiting hours.

b. One member of staff directs ambulation of patient when several are involved in task.

c. Necessary supplies and equipment are assembled and prepared prior to initiation of treatment.

d. Provision is made so that patient receives adequate and prompt assistance at mealtime.

e. When patient is acutely ill, he receives care before patients with less acute needs.

f. Staff assignment plans reflect consideration of patient's needs.

APPENDIX C

Individual Frame of Reference

INDIVIDUAL FRAME OF REFERENCE

Each rater completes her individual Frame of Reference Card according to the instructions on the card.* This framework may then be used for reference whenever she makes a judgment about the quality of any nurse actions performed in providing care for the patient. Should settings change markedly, such as from a geriatric hospital ward to a well-baby clinic, the rater may want to change the names of the staff nurses whom she recalls having worked in the particular specialized setting, but the general process of developing the frame of reference and applying the scale of the standard of measurement remains the same.

Slater Nursing Performance Rating Scale Rater _____

INDIVIDUAL FRAME OF REFERENCE CARD

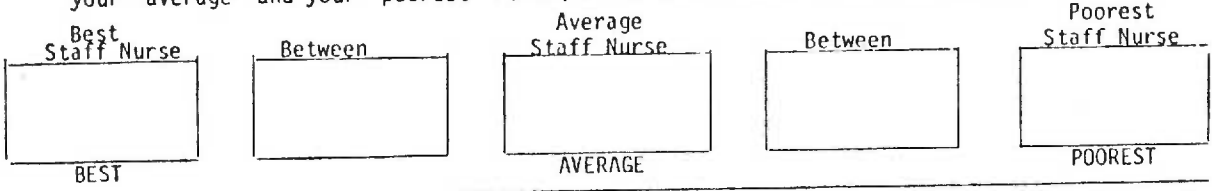
Write the names of staff nurses whom you know or have known in their respective boxes:

1. Write the name of the nurse whom you consider to be the best staff nurse you have known (the nurse you would like to have care for you if you were ill) in the box labeled "Best Staff Nurse."

2. Think of the nurse you consider to be the poorest staff nurse you have even known; write her name in the box on the far right, labeled "Poorest Staff Nurse."

3. Think of a nurse whom you consider to be a typical or average staff nurse, neither noticeably good or noticeably poor; write her name in the middle box, labeled "Average Staff Nurse."

4. Think of a nurse who falls between your "best" and your "average" nurse and one who falls between your "average" and your "poorest" nurse; write their names in the respective boxes.



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*Adopted from Slater Nurse Performance Rating Scale; Detroit: College of Nursing Wayne State University, 1967, p. 29.

APPENDIX D

A Fact Sheet about Qualpacs

A FACT SHEET ABOUT QUALPACS

For distribution to Head Nurses
and Ward Nursing Personnel

WHAT: A Survey to Evaluate the Quality and Conditions of Delivery of Nursing Care to Patients at _____ Hospital

Conducted by the Department of Nursing

WHEN: Date to Date

WHY:

I. To examine the quality of care provided to patients at _____ Hospital.

II. To identify ward activities and conditions which might influence quality of care (e.g. number of personnel, number of treatments, equipment, number of critical patients, etc.)

III. To provide information to Department of Nursing (supervisory and unit personnel) to serve as a base for planning for personnel assignment, inservice education, etc.

Developed by Kathlene F. Monahan

How will study be conducted?

The Nurse Observer will spend a two hour period observing the selected patient(s). Five to six patients will be observed on each unit. The observer will observe the care received by the patient(s) and ascribe ratings to pertinent items on the Quality Patient Care Scale.

The Nurse Observer will not participate or intervene in any nursing actions unless in her judgment, not to do so would be dangerous for the patient.

The Nurse Observer will sit in the patient's unit during the observation period, in an area where it is possible to observe the patient, and yet be as unobstrusive as possible.

She will be making recordings of her observations, therefore, she will be "turning pages" etc. Conversation with her by personnel and patients is to be discouraged during the observation periods. After she has finished her observation period, if the patient or personnel desire any discussion, this is permitted.

THE STUDY IS NOT AN EFFICIENCY RATING OF PERSONNEL. Names of personnel are not recorded. The study is concerned with what nursing care the selected patient receives regardless of who does it. From the records the nurse observer keeps, it would not be possible to retrieve a person's name, and give an efficiency rating.

Patient Information:

The Nurse Observer will examine the patients chart, kardex so that she has information concerning the needs of the patient that she will be observing. In addition she may need to supplement her information by spending a short time consulting with the head nurse or nurse who is providing care for the selected patient.

What help is needed from head nurses?

A. Help in identification and selection of patients.

1. The Nurse Observer will seek the charge nurses assistance in identification of patients for the study.

2. The charge nurse will be contacted, and consulted regarding the identification of patients who may be expected to receive a number of nursing interactions and interventions.

3.

3. The observer has to observe patients for whom something is being done. If patients are scheduled for "off-ward" activities, they should not be in the study.

B. Introduction to staff.

1. Briefly explain that the study is to look at what activities nursing personnel do for patients.

2. That the observer will be sitting in the patients unit and will be "thumbing" papers.

3. That it is not an efficiency rating.

4. Personnel are requested to continue their normal activities, and disregard the presence of the observer.

C. Introduction to patients.

A nurse who knows the patient should:

a. Introduce the observer to all patients in the immediate study area.

b. Explain briefly what the observer will be doing and why she is there.

c. Explain that the observer will be "observing" and writing and will not be talking or working with patients.

d. It is not necessary to state specifically which patient is being observed.

e. The observer will wear a lab coat.

Schedule for Observations:

1. Observations for each ward will be schedule on successive days, for the time needed (usually 2 to 3 days.)

2. You will be notified the day before, when the observer plans to begin observations on your ward.

3. Please do not make any unusual modifications of your ward assignments.

APPENDIX E

Consent Form for Human Research

THE OREGON HEALTH SCIENCES UNIVERSITY

School of Nursing
Office of the Associate Dean for
Academic Affairs

3181 S.W. Sam Jackson Park Road Portland, Oregon 97201 (503) 225-7893

CONSENT FORM FOR HUMAN RESEARCH

I, _____, herewith agree to
(First Name) (Initial) (Last Name)
serve as a subject for the study named, "A Study of the Relationship Between Problem-Oriented Records Using Nursing Diagnoses and the Quality of Nursing Care" by Laura Bertram, R.N., B.S.N., under the supervision of Christine A. Tanner, R.N., Ph.D. This study explores elements of nursing care to patients. My participation in the study requires that I allow a nurse observer to be at my bedside for a two-hour period to observe the care I receive and to study my hospital record. I may benefit by participation as the evaluation of the care I receive may lead to improvement of that care. I understand that participation in this study will involve no risk for me. However, it will reduce the privacy of my interactions with the nursing staff for the two-hour observation period. The information obtained will be kept confidential. My name will not appear on any project records and anonymity will be maintained by the use of code numbers. Laura Bertram has discussed this study with me and has offered to answer any question I may have. I may call her at 232-1095.

I understand I may refuse to participate or withdraw from this study at any time without affecting my relationship with, or treatment at, the Oregon Health Sciences University.

I understand what will be required of me and agree to participate in this study as described above.

_____ _____
(Date) (Participant Signature)

_____
(Witness Signature)

APPENDIX F

Qualpacs Rater's Notes
and
Information Face Sheet

QUALPACS Rater's Notes

for

Assessment and Planning Care

PATIENT _____

ORDERS, NEEDS, NURSING ACTIONS:

Diet (meals, fluids, nourishment)

Medications

Treatments: (Dressings, irrigations)

Special care:
- a. colostomy, trach., etc.
- b. skin—bath, lotion, etc.
- c. traction, cast
- d. decubiti

Observation of condition
- a. Direct
- b. Monitors (V.S., Pacemakers, etc.)

Diag Tests
- a. On ward
- b. Off ward

Activity (bedrest, ambulation, etc.)

QUALPACS Rater's Notes, continued

Sensory deficit (blind, aphasia, deaf)

Safety

Teaching Patient and Family

Socialization and diversion

Multiple services (referrals, consultations)

Reporting and recording

Planning for continuity of care

Other

Rater No. _____ ID No. _____
Date _____

GENERAL DATA

Levels of Care
I _____ _____ 53-54
II _____ _____ 55-56
III _____ _____ 57-58

Personnel Code
RN _____ _____ 59
LPN _____ _____ 60
SN _____ _____ 61
Aide _____ _____ 62
Clerk _____ _____ 63

Productivity _____ _____ 64-66

Diagnoses
Admission _____
Current _____

Patient Condition _____ _____ 67

Date of Admission _____

Acuity _____ _____ 68-70

APPENDIX G

Records Audit

RECORDS AUDIT

Date:_____ Reviewed by:_____

Unit:_____ Case #:_____

Shift:_____ Admission Date:_____

CRITERIA	SCORE			COMMENTS
	Yes, all	Yes, but not all	No, none	
	2	1	0	
Data Base				
1 The nursing assessment has been completed.				29____
2 Problems identified in the assessment appear on the problem list.				30____
Problem List				
3 All diagnoses are factually supported.				31____
4 Active and inactive or resolved problems are entered correctly.				32____
5 The list is current.				33____
Nursing Diagnoses				
6 The ND written on the Nursing Care Plan are consistent with the Accepted List of Nursing Diagnoses.				34____
Initial Plans				
7 An initial plan is made for each identified problem.				35____
8 Under "P" only nursing orders are present.				36____
9 There is a clear relationship between the plan and the problem.				37____
Progress Notes				
S-				38____
10 In the progress notes under "S" notations include only what the patient/significant others say re: problems, complaints, symptoms.				
11 There is a clear relationship between the subjective data and the problem.				39____
O-				
12 Under "O" notations include only what nurse observes, ie. lab values, signs and nursing actions.				40____
13 Under "O" standard notations (ie. VSS, IV infusing, suction x 2, TCDB) are recorded only as clarification for the assessment.				41____

	CRITERIA	SCORE			COMMENTS
		Yes, all	Yes, but not all	No, none	
		2	1	0	
14	There is a clear relationship between the objective data and the problem.				42____
	A-				
15	Under "A" notations include only evaluative statements based on S & O.				43____
16	There is a clear relationship between the assessment and the problem.				44____
	P-				
17	Under "P" only nursing orders are present.				45____
18	There is a clear relationship between the plan and the problem.				46____
19	The plan is appropriate for the assessment.				47____
20	The plan includes referals to other team members when appropriate.				48____
21	Flow sheets are completed each day.				49____
22	Each current nursing order is on the Nursing Care Plan.				50____
Evaluation					
23	The status of each identified problem is reported on every 72 hours.				51____
24	There is evidence that the plans have been initiated and evaluated for effectiveness.				52____

APPENDIX H

Accepted List of Nursing Diagnoses

LIST OF NURSING DIAGNOSES ACCEPTED AT THE FOURTH NATIONAL CONFERENCE

Airway Clearance, Ineffective
Bowel Elimination, Alterations in: Constipation
Bowel Elimination, Alterations in: Diarrhea
Bowel Elimination, Alterations in: Incontinence
Breathing Patterns, Ineffective
Cardiac Output, Alterations in: Decreased
Comfort, Alterations in: Pain
Communication, Impaired Verbal
Coping, Ineffective Individual
Coping, Ineffective Family: Compromised
Coping, Ineffective Family: Disabling
Coping, Family: Potential for Growth
Diversional Activity, Deficit
Fear
Fluid Volume Deficit, Actual
Fluid Volume Deficit, Potential
Gas Exchange, Impaired
Grieving, Anticipatory
Grieving, Dysfunctional
Home Maintenance Management, Impaired
Injury, Potential for
Knowledge Deficit (specify)
Mobility, Impaired Physical
Non-compliance (specify)
Nutrition, Alterations in: Less Than Body Requirements
Nutrition, Alterations in: More Than Body Requirements
Nutrition, Alterations in: Potential For More Than Body Requirements
Parenting, Alterations in: Actual
Parenting, Alterations in: Potential
Rape-Trauma Syndrome
Self-Care Deficit (specify level: Feeding, Bathing/hygiene, Dressing/grooming, Toileting)
Self-concept, Disturbance in
Sensory Perceptual Alterations
Sexual Dysfunction
Skin Integrity, Impairment of: Actual
Skin Integrity, Impairment of: Potential
Sleep Pattern Disturbance
Spiritual Distress (Distress of the Human Spirit)
Thought Processes, Alterations in
Tissue Perfusion, Alterations in
Urinary Elimination, Alteration in Patterns
Violence, Potential for

Diagnoses "Accepted" without defining characteristics,
(therefore, unacceptable, but to be listed separately,
as diagnoses To-Be-Developed: "TBD")

Cognitive Dissonance TBD
Family Dynamics, Alterations in TBD
Fluid Volume, Alterations in, Excess: Potential for TBD
Memory Deficit TBD
Rest-activity Pattern, Ineffective TBD
Role Disturbance TBD
Social Isolation TBD

AN ABSTRACT OF THE THESIS OF

Laura A. Bertram

For the MASTER OF NURSING

Title: A Study of the Relationship Between Problem-Oriented Records Using Nursing Diagnoses and the Quality of Nursing Care

Approved: _____
Christine A. Tanner, R.N., Ph.D., Thesis Advisor

The purpose of this study was to generate information which would contribute to the evaluation of the relationship between problem-oriented records using nursing diagnoses and the nursing care received by patients. Both problem-oriented records (Kinney, 1974; Leonard, 1974; Mitchell, 1973) and nursing diagnoses (Gordon, 1978; Kim, 1982; McCourt, 1982; Roy, 1975) have been espoused to be positively related to quality of care.

The Quality of Patient Care Scale (Qualpacs) was used to rate the nursing care on 30 patients. A records audit was used to evaluate the extent to which problem-oriented recording using nursing diagnoses was being used on the records of the same 30 patients.

A pilot study was done prior to the main study to establish inter-related reliability. A descriptive correlational design was used for the main study. It was done over a four week period, during the evening shift only, on randomly selected patients. The study took place on a 20 bed surgical unit in a large metropolitan hospital.

The hypothesis tested was: There will be a positive relationship between the quality of care received by patients as measured by a

process measure and the quality of records using problem-oriented charting and nursing diagnoses.

Pearson's Product Moment Correlation Coefficient was run between the Total scores from each audit and the corresponding Grand Mean scores from the Qualpacs observations. This correlation was positive, but was not statistically significant. Therefore, the hypothesis was not supported.

This finding was not consistent with the bulk of literature on the subject. A number of theoretical problems were identified which may have contributed to this discrepancy. Difficulties with the instruments used in the study may also have affected the results. Further research is needed to test the hypothesis.