DOCUMENTATION BY NURSES OF THE NURSING PROCESS IN THE DISCHARGED PATIENT RECORD

by

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To my husband, Jim, whose support, love and encouragement made this all possible.

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CHAPTER 1

INTRODUCTION

Statement of the Problem

There is general agreement within the nursing profession that the nursing process is the core and essence of nursing, central to all nursing actions, and applicable within any frame of reference, concept, theory, or philosophy. The nursing process is defined by Yura and Walsh (1980) as an orderly, systematic manner of determining the client's problems, making plans to solve them, initiating the plan or assigning others to implement it, and evaluating the extent to which the plan was effective in resolving the problems identified. The nursing process is flexible and adaptable, adjustable to a number of variables, yet sufficiently structured so as to provide a base from which all systematic nursing actions can proceed. The movement toward full professional status charges nurses with several changes in the discipline, one being the responsibility of establishing nursing as a research-based practice (Stevens, 1979). In one sense, the nursing process promotes such practice in that it utilizes the principles of scientific method in the form of systematic problem solving and planning in order to assure that the outcome of nursing care will be according to plan (Jacox, 1974).

The goals of the continuing development of the nursing process (Yura & Walsh, 1980) are improved history taking, more accurate nursing diagnoses, more effective priority setting, improved design of the nursing care plan,

more astute specifications of expected patient behaviors, more effective recording of observations about the patient, more purposeful and effective nurse actions, more emphasis on evaluation as well as on the development of tools for evaluation, and more accurate judgment concerning what, how, when and to whom to communicate the nursing process.

Despite the fact that the nursing process is an essential part of today's nursing curricula and serves as a basis for the newly developed State Test Pool Examination (1980), there are indications that registered nurses are not utilizing this approach consistently in their work settings. This writer has observed through retrospective audits that some nurses do not have an integrated understanding of the nursing process. Personal communication with the Joint Commission on Accreditation of Hospitals (JCAH) surveyors indicate that they have made similar observations. (See Appendix A)

As the scope of nursing practice expands as evidenced by nurse practitioners' prescription privileges and third party payment, accountability for quality of practice becomes a critical issue both to the individual nurse and to the profession. The need for self-evaluation is apparent. Nurses are answerable, states Phaneuf (1972), to themselves as practitioners; to patients and families; to physicians and others who participate in the care of patients; to the facilities in which they practice; and to the nursing profession, which is in turn accountable to the community.

There are three major approaches to evaluating the quality of nursing practice: the evaluation of structures within which the care is given, evaluation of outcomes, and evaluation of the process of care (Donabedian, 1969). The structure of the nursing department is probably the easiest

to evaluate since it deals with discreet and concrete statistics such as number of personnel, educational preparation, and budget. Outcome is of the most consequence; however, since it is not subject to control variables, it is difficult to measure the specific impact of nursing care. This writer agrees with Phaneuf (1976) that the nursing process is totally under the control of nurses, while structure and outcome are not. Thus, evaluation of the process of care is the most appropriate as it is the basis for nursing practice and the delivery of nursing care.

Audits are mechanisms for evaluating the quality of nursing care, and entail rigorous assessment of the nursing process. For example, through the auditing process, strengths and weaknesses can be identified. From this identification, recommendations for improvements in care can evolve. Phaneuf (1976) writes that these recommendations may best be evaluated through a retrospective audit, which permits appraisal of the complete cycle of nursing practice; final judgments cannot properly be made until the process of care has ended.

In August, 1980, the Joint Commission on Accreditation of Hospitals (JCAH) survey team, within the study hospital, identified a nursing deficiency with the following comments: "The nursing process is not integrated into the patient's plan of care." The validity of this deficiency was questioned, and as a result, this writer determined to study the nursing process to see if registered nurses are documenting on nurses' notes in the patient record. The Craig Audit Tool (1978) was used to evaluate the quality of care provided through the appraisal of the nursing process as reflected in the discharged patient care records. More specifically, the Craig Audit Tool was used to measure documentation of the nursing

process by registered nurses in the discharged patient record.

Purpose of the Study

The purpose of this study was to determine the extent to which registered nurses were documenting the nursing process in the patient record.

Conceptual Framework

Nursing, ideally, is a dynamic and systematic problem-solving approach to the delivery of nursing care, and encompasses the elements of the nursing process. Documentation of delivery of care reflects the assimilation of the nursing process, not as an artifact, but as actual practice. A discrepency seems to exist between nurses' utilization and nurses' documentation of the process.

Craig chose a score of 40% as the minimal acceptable standard for documentation of the nursing process by registered nurses on the nurses' notes in the discharged patient record. A score below forty percent reflects a deficiency in the documentation of the nursing process by registered nurses on the nurses' notes in the patient record.

Hypotheses:

To determine the extent to which the nursing process is documented, four hypotheses were tested. These were:

1. Documentation by nurses of the assessment component of the nursing process as measured by the Craig Audit Tool will be higher than 40%.

2. Documentation by nurses of the planning component of the nursing process as measured by the Craig Audit Tool will be higher than 40%.

3. Documentation by nurses of the implementation component of the nursing process as measured by the Craig Audit Tool will be higher than 40%.

4. Documentation by nurses of the evaluation component of the nursing process as measured by the Craig Audit Tool will be higher than 40%.

LITERATURE REVIEW

The literature review addressed four major areas: 1) the nursing process; 2) criteria and standards of the nursing audit; 3) documentation of the nursing process; and 4) the approaches and methods of monitoring nursing care.

Nursing Process

Over one hundred years ago, Florence Nightingale described nursing as a process that "puts the patient in the best condition for nature to act upon him." Care patterns established by Florence Nightingale (1820-1910) and Clara Barton (1821-1912) were chiefly concerned with procedures which were aimed at providing an environment of cleanliness, comfort and safety for the enhancement of nature's work of healing.

This concept was relabelled total patient care and was introduced by Lydia Hall (1955), who also initially coined the term "nursing process." Kreuter (1957) discussed the steps of the nursing process as nurses know them today, but did not label them as such, using instead words like "co-ordination", "planning" and "evaluating" nursing care.

The nursing process described by Abdellah (1960) utilizes the problem-solving process and involves identifying the problem, selecting pertinent data, formulating hypotheses, testing hypotheses through the collection of data, and revising hypotheses where necessary on the basis of professional practice. Abdellah states that, by formalizing practice techniques, nurses can then clearly describe ways for performing specific actions so that some particular results will be achieved.

In Orlando's text, The Dynamic Nurse-Patient Relationship, published at the begining of the 1960s, the term nursing process was used to define phases of the process in terms of interpersonal relationships.

In 1967, the Western Interstate Commission on Higher Education Committee involved with curriculum development defined the nursing process as "...that which goes on between a patient and nurse in a given setting; it incorporates the behaviors of patient and nurse and the resulting interaction. The steps in the process are: perception, communication, interpretation, intervention, and evaluation." During this same year, the faculty at the school of nursing at The Catholic University of America identified the phases of the nursing process as: assessing, planning, implementing, and evaluating. The 1973 American Nurses Association Standards of Nursing Practice specifically incorporates the nursing process as a basis for established standards.

LaMonica (1979) describes the nursing process as the scientific method used to assist the practitioner to systematically assess, plan, implement and evaluate quality, and individualize professional nursing care. By progressing through each phase of the nursing process, i.e., assessment, planning, implementation and evaluation, the nurse ensures that the care provided to each client will be geared to individual patient needs. The nursing process which is dynamic and evolutionary begins with simple methods of assessment, and moves toward analytical thinking, which is integrated into delivery of care. In their latest book, Yura and Walsh (1980) state, that the nursing process is the core and essence of nursing and that it is central to all nursing actions, applicable in any setting, within the frame of reference, in concept, theory, or philosophy.

Today nursing practice is generally defined as a dynamic, caring,

helping relationship in which the nurse facilitates the client to achieve and maintain a level of wellness (Orem, 1980; Roy, 1980; King, 1971; La-Monica, 1979). Nurses accomplish this goal by applying knowledge and skills from nursing and related fields using the nursing process.

Widespread support for the utilization of the nursing process is apparent as noted by the following examples. The sanction of the nursing process is affirmed by the American Nurses' Association Standards and nursing literature supports it as the dominant modality in nursing. The support of the nursing process is evident in the formulation of generic standards and standards for specialty-practice groups. The Standards of Nursing Practice developed by the Congress for Nursing Practice (1973) outline the body of knowledge and understanding which is required of the registered nurse. The Standards are stated according to a systematic approach to nursing practice: the assessment of the patient's status, the plan of nursing actions, the implementation of the plan, and the evaluation of the effectiveness of the plan in meeting objectives. The Standards for Nursing Practice apply to nursing practice in all settings.

In November 1978, the Council of Baccalaureate and Higher Degree Programs of the National League for Nursing determined that the graduates of the baccalaureate degree program in nursing had developed skills to utilize the nursing process. The graduates could assess health status and health potential, and plan, implement, and evaluate nursing care.

Entry to the practice of nursing in the United States requires a candidate for licensure to pass an examination. The State Board Test Pool examination is recognized by legal authorities and developed by

the National Council of State Boards of Nursing. The nursing process, which serves as one dimension of the "Test Plan" for the Registered Nurse State Board Test Pool Examination (1980), requires a set of nursing behaviors that can be tested in a variety of patient situations. Nursing behaviors to be tested are grouped under the broad categories of assessing, analyzing, planning, implementing and evaluating.

The Joint Commission on Accreditation of Hospitals Manual, Nursing Services Standard IV, states: "Individual, goal-directed nursing care shall be provided to patients through the use of the nursing process (assessment, planning, intervention, evaluation) and shall be documented for each hospitalized patient from admission through discharge." (1981, p.118).

Criteria and Standards and the Nursing Audit

Diddle (1976) noted that considering retrospective chart review as a quality assurance measure was acceptable in the Veterans Administration Research Hospital, Chicago, Illinois. That hospital's philosophy maintained that "Care is incomplete until it is recorded." Since the chart was considered a legal document, it was expected to represent accurately the care provided and was, therefore, an acceptable method for public accountability.

To ensure that care is appraised as objectively as possible, criteria and standards are essential (Phaneuf, 1976). The audit developed at Veterans Administration Research Hospital included criteria and standards related to the nursing process and the outcomes of care. Specific health problems were selected, and a nursing committee was initiated to develop the criteria and standards in relation to each health problem which would be appraised by the audit tool. Diddle emphasized that

quality assurance without specific standards is virtually impossible.

Easton (1976) emphasized that the auditing of records for process is complex and that criteria, with standards, should be used. He states that it is unfair to the health provider if auditing is carried out without the development of criteria and standards as the provider is unaware of the evaluator's expectations.

The problem-oriented record introduced by Weed in 1964 had been of interest because of the efficiency of the use of an audit with the medical record (Fletcher, 1974). Although results of a study conducted by Fletcher did not demonstrate any significant difference in the speed or accuracy of auditing the problem-oriented record as compared to the traditional source oriented records, they did emphasize the limitations of using the medical record for the assessment of quality care without specific criteria and standards.

Documentation and the Nursing Process

One cannot discuss the nursing process without reference to the documentation of care which would reflect it. A properly documented record describes not only the care the patient received while hospitalized, but also the outcomes of that care. Vasey (1980) writes that documentation of nursing care provides for:

1. Data needed to plan patient care and insure continuity of that care.
2. Communication between health-team professionals.
3. Written evidence of why the patient received specific nursing care, responses to that care, and revisions made in that care.
4. A method to review, study, and evaluate care in preparation for an audit.
5. A legal record.
6. Data for use in research and education.

The accurate recording and reporting of facts, including the evaluation of the whole care of the patient, is listed as one of the functions of nursing by Lesnik and Anderson (1955). "The material exists but it is inaccessible" is a statement attributed to Florence Nightingale (1967) in referring to the need for systematic and comparable data on patients for the purpose of improving treatment of patients and hospital operations. The expectation has been that nurses, through their knowledge and experience, would acquire the ability to make accurate, precise and concise notations of critical data in patients' records, based on scientific observations and assessment related to the identified problems of the patient and his plan of care (Matheney, 1968). Previous unpublished audits at the study hospital reveal that this expectation is not met.

Development of the nursing process utilized in patient care management is built upon the fundamental principles of the scientific method. The concept of the problem-oriented system described by Weed (1970) provided an acceptable format for documentation of patient care management that would reflect the nursing process. The system popularized by Weed includes the following components: the defined data base, the complete problem list, the initial plans and the progress notes. When the problem-solving approach is applied in recording the nursing process, the components are: collecting a data base, developing a complete problem list, developing an initial plan, writing nursing orders, and evaluating the progress of problem resolution (Vaughn-Wrobel & Henderson, 1976). From the data base a list of problems is developed and, if related, grouped accordingly by nursing diagnoses. The nursing diagnosis list becomes a guide for planning nursing care.

An initial nursing plan is documented for each nursing diagnosis. Independent nursing functions are then developed to meet patient care objectives. Deadlines or due dates are established to evaluate patient progress. A nursing diagnosis is supported in writing by at least four components: subjective, objective, assessment and plan. The "subjective" component is the view of the problem by the patient; the "objective" is the view of the problem by the nurse. In the "assessment", the nurse processes and validates the collected data and concludes with a nursing diagnosis. The "plan" is evolved or modified in accordance with current and revised information. With this problem-oriented approach, not only are the four phases of the nursing process documented, but they are patient-centered and dynamic.

Within the problem-oriented system, the patient record is a tool for problem-solving and provides a thorough and systematic means for evaluation of the entire process of patient care management. It can be said that the nursing process lends itself to the components of the problem-oriented system or, on the other hand, that the problem-oriented system facilitates the documentation of the nursing process. Nevertheless, the structured format of the problem-oriented system provides a vehicle for recording the nursing process and facilitates the retrospective and concurrent auditing of records.

Approaches and Methods for Monitoring Nursing Care

As stated earlier, there are three approaches to evaluating care: structure, process and outcomes (Donabedian, 1969). Structural components refer to the way an organization is systematized, and include considerations of purpose and agency, authority, fiscal and organizational

characteristics, qualifications of professionals and other employees, physical facilities, status of accreditation and certification (Phaneuf, 1976). Stevens (1979) identifies process standards as measures of the activities of the nurse as an individual performer rather than the standardized aspect of care. According to Phaneuf, process evaluation includes "appraisal of all major and significant minor steps taken in the care of the patient, with attention to the rationale for and the sequence of the steps, and the degree to which they help the patient to reach specified and attainable goals." (1976, p.21) The evaluation of the outcomes of care is directed at the end result of care. Shapiro (1967) states: "The term 'end result' refers to some measureable aspect of health status which is influenced by a particular element or array...of elements...of care."

To date, no significant degree of agreement exists among professionals regarding which approach is most useful. Donabedian (1969) believes a well-rounded system of quality appraisal would include concurrent assessments of structure, process, and end results, to the extent that each of these is observable and measureable under the constraints inherent in any given setting. Nevertheless, different experts have opted for different methods of assessing nursing care. During the past decade, several nursing assessment instruments have been developed and tested for reliability and validity. These instruments evaluate patient care both concurrently and retrospectively. A concurrent evaluation is completed while the patient is receiving care, whereas a retrospective evaluation is an appraisal of the completed cycle of care. The Quality Patient Care Scale (Qualpacs) developed by Wandelt and Ager (1976) is designed

to evaluate quality of patient care while care is in progress. This instrument consists of 68 items selected as representative elements of nursing care and is designed to sum ratings of quality of care delivered to patients in any setting where nurse-patient interactions occur. The objective of this instrument is to quantify the overall nursing care as received by the patient.

A study conducted through the efforts of the Nursing Research Branch, Division of Nursing of the National Institute of Health and the Rush-Presbyterian-St. Luke's Medical Center, resulted in the development of a process monitoring instrument called, The Rush-Medicus Nursing Process methodology (1976). As with the Qualpacs, this study provided a concurrent measure of patient care. Nursing process criteria were developed on the basis of the nursing process model with each phase of the process delineated in detail.

An example of a retrospective audit is the Slater Scale (1975), which measures individual nurse competencies in the clinical setting. A second retrospective audit is Phaneuf's Nursing Audit, a 50-item scale which measures the quality of care received by a patient during a particualr cycle of care. This audit focuses on nursing process and suggests concrete studies to persons concerned with quality control in a variety of patient care settings.

Craig (1978) developed an instrument based on the Standard of Nursing Practice for Registered Nurses at the College of Nurses of Ontario, in Toronto, Ontario, Canada. Craig's retrospective audit utilized those standards relevant to the appraisal of the nursing process using the patient record. Criteria and standards were developed to appraise the

four phases of the nursing process: assessment, planning, implementation and evaluation. A scoring system was developed to rate the responses elicited by the standard using a five point ordinal scale. The documented information was appraised as excellent, good, fair, deficient or poor and rated with a corresponding numerical score. On completion of the audit, the numerical score was tallied and a percentage score determined. On the assumption that the care provided was documented, the audit instrument discriminated between poor, deficient, fair, good and excellent nursing care on the discharged records.

Craig's audit instrument was chosen because it provides a way to measure nursing care provided, as documented in the patient records. It also determines if certain elements of the nursing process are documented by registered nurses on the nurses' notes in the patient's record. The results of this audit could significantly affect the quality of nursing care provided if used to determine the strengths which could be maintained and to determine weaknesses for which recommendations could be made for improvement.

CHAPTER 2

METHOD

Description of the Study

This research project was an evaluation of the patient's record to determine to what extent the nurses' notes reflect documentation of the nursing process. For the purpose of this study, the records examined were those of veterans discharged during a one month period from a Veterans Administration Medical Center. Results of this audit are of current value since the information will be used to determine the need to improve documentation of the nursing process.

Setting of the Study

The setting for this study was a 427 bed rural Veterans Administration Medical Center (VAMC). This medical center has the following nursing areas: surgical, medical, respiratory care, intensive care, long term care and psychiatric unit. The care areas are designated for this study according to specialty area and coded as follows:

Respiratory Care Unit	RCU
Intensive Care Unit	ICU
Surgery Unit	SURG
Medical Unit	MED
Long Term Care Unit	LTC
Psychiatric Unit	PSYCH

Data Collecting Instrument

The Craig Audit Tool was selected to measure documentation of the nursing process by registered nurses. Criteria and standards were developed by Dorothy Craig (1978) to appraise the four phases of the nursing process: assessment, planning, implementation and evaluation. This

audit consists of thirty-six criteria: eleven for the assessment phase, nine for the planning phase, eleven for the implementation phase and five for the evaluation phase. (See Appendix B) When developing this instrument, content validity was established if each criterion/standard had some information documented in at least fifty percent of the records reviewed. After the pre-test, Craig concluded that the audit tool contained all of the significant variables which would be required in an appraisal of the nursing process.

Interrater reliability, referred to in Craig's study as "between-rater" reliability was computed using three raters: this investigator, a mental health nursing clinical specialist and a cardiac rehabilitation nursing clinical specialist. Reliability testing followed Craig's recommendations, which are also in agreement with Phaneuf's (1976) findings and include:

1. That the audit team consisted of this writer and two nurses prepared at the Master's level on the Veterans Administration Medical Center nursing staff. (Adapted from Phaneuf's Nursing Audit, 1976)

2. That the audit team developed a philosophy for the nursing audit.

3. That the audit team had an adequate orientation which included:

   a. a review of the audit instrument

   b. a review of the conceptual framework on which the audit was based.

   c. a requirement that each auditor reviewed a minimum of the same ten records so results of their audit could be compared statistically.

4. The audit team established between-rater reliability by statistically comparing the data generated by the three nurse-raters, auditing ten discharged patient records using Craig's Audit Tool.

5. That reliability was acceptable when, in eight times out of 10, all three auditors achieved the same score, or there was agree-

ment on two scores with the third score close. To consider a score "close", there will be not more than one point difference between scores using this standard.

Scoring

The scoring system rated the responses elicited by the standard using a five point decimal scale as follows:

1. The documented information was appraised as excellent, good, fair, deficient, or poor and rated with corresponding numerical score.

2. Each criterion was rated by placing a check in the appropriate space on the 5-point rating scale.

3. The five points on the scale were designated excellent, good, fair, deficient and poor. These points have numerical values of four for excellent, three for good, two for fair, one for deficient and zero for poor. On completion of the audit, the numerical score was totalled for each criterion and component and a percentage score determined by:

$$\frac{\text{Total Score obtained on audit}}{\text{Total Perfect Audit Score - number of criterion measures not applicable x 4}} \times 100 = \%\ \text{measure of quality of care provided}$$

The documented information in the record was rated against the standards in the following manner:

Excellent: Scored four points if all of the information required to meet the standard was documented.

Good: Scored three points if most of the information required to meet the standard was documented.

Fair: Scored two points if only some of the information required to meet the standard was documented.

Deficient: Scored one point if there was some evidence that an attempt to document the response required to meet the standard.

Poor: Scored zero points if there was no evidence of an attempt to document the response required to meet the standard.

Not Applicable: If any criteria/standards were not applicable to the situation, the non-applicable measure was checked and

a total of checks tallied at the end of the auditing procedure.

Data Collecting Procedure

Permission was requested and granted through the usual procedures established by the study facility. (See Appendix C)

The records of sixty patients discharged during the month of March 1981, were randomly selected for auditing in the following way: The Veterans Administration Medical Center "Gains and Lossess" data sheet was used to list discharges from each of the previously described units for the month of March, 1981. Every name in order was selected until the defined total number was reached. A percentage of the discharges for each unit was based on the unit's total discharge rate for the month of March. The number of patient records audited per nursing unit was: Respiratory Care Unit - 6, Intensive Care Unit - 2, Surgery Unit - 14, Medical Unit - 20, Psychiatric Unit - 16, and Long Term Care Unit - 2.

The month of March was chosen in order to ensure record availability since veterans tend to be mobile and their records are sent to the facility delivering current care. Additionally, all registered nurses at this facility were required to participate in a six-hour nursing process workshop during the months of April and May, 1981, so these months and subsequent months could have contaminated the sample under study.

Three criteria were used to establish eligibility for inclusion in the study:

1. The discharged patient record was limited to a Veterans Administration Medical Center in Oregon.

2. The discharged patient record was excluded if the patient's last hospitalization stay was more than six months.

3. The discharged patient record was excluded if the patient's length of stay was less than forty-eight hours.

Pilot Study

A pilot study was conducted to provide the three raters with audit tool familiarity and to generate between-rater reliability. The pilot study sample consisted of ten discharged patient records. On completion of the ten record audits, the three raters analyzed scores and discussed the criterion where disagreement existed. Discussion continued until all three raters agreed on each criteria. In addition, raters clarified specific factors for those criteria requiring more discussion than usual, before consenual validation. It was anticipated that this additional information would increase between-rater reliability. Ten more patient records were audited and at this time, between-rater reliability was established according to Craig's standards which were: that reliability was acceptable when, in eight times out of 10, all three auditors achieved the same score, or there was agreement on two scores with the third score close. To consider a score "close", there will be not more than one point difference between scores.

Study Procedure

The procedure for the actual study was the same as procedures used for the pilot, except that each record was audited by only one nurse-rater. Since between-rater reliability had been established, auditing records individually was possible.

Data Analysis

The data collected from the sixty discharged patient records within the sample from the six nursing units was summed for each of the four components of the nursing process. After each rater completed an audit,

the scores were tabulated and all criteria under each of the four components was totaled. Scores from each of the four components were then totaled for an overall score.

The total score for each component of the nursing process for each subject was divided by the number of criteria rated to yield an item mean score. The item mean scores for each component were summed, and this sum was carried to two decimal places. The numerical labels for "excellent" and for "concern" established for Craig's Audit Tool were used as designated, for example: 80-100% as excellent, and below 40% as the level of deficiency. Ratings of 40% and above were considered in the range of acceptability.

Confidentiality

Confidentiality of individual nurses giving care was strictly maintained both during and after this study. The data were collected without recording the nurses' names in any way. The data were reported to the Chief, Nursing Service in a statistical form only.

CHAPTER 3

RESULTS AND DISCUSSION

The results of this study are presented as follows: (a) sample of patient records involved in the study, (b) results related to the four hypotheses, (c) results related to each of the four components of the nursing process and (d) interpretation of the documentation ranges according to Craig's Audit Tool. A discussion of the results and their interpretation is included.

Sample

Records of sixty patients discharged during the month of March, 1981, were used. As discussed in the previous section, the number of records selected from each nursing unit was based on the unit's total discharge rate for that month. The distribution is shown in Table 1 below:

TABLE 1

Number of Patient Records Audited per Nursing Unit

Respiratory Care Unit (RCU)	6
Intensive Care Unit (ICU)	2
Surgery Unit (Surg)	14
Medical Unit (Med)	20
Psychiatric Unit (Psych)	16
Long Term Care Unit (LTC)	2
Total	60

The 106 registered nurses who document on patient records at the study facility are educationally prepared at different levels: 51% are graduates of diploma programs, 19% have an Associate in Science degree,

24% have a Bachelor of Science degree and 6% have a Masters Degree.

Results of Hypotheses

There were four hypotheses tested by this study:

1. Documentation by nurses of the assessment component of the nursing process as measured by the Craig Audit Tool will be higher than 40%.

2. Documentation by nurses of the planning component of the nursing process as measured by the Craig Audit Tool will be higher than 40%.

3. Documentation by nurses of the implementation component of the nursing process as measured by the Craig Audit Tool will be higher than 40%.

4. Documentation by nurses of the evaluation component of the nursing process as measured by the Craig Audit Tool will be higher than 40%.

To test these four hypotheses, a comparison of the total score achieved for each of the four components of the nursing process was made. The level of documentation by registered nurses within the study facility was examined to identify areas of strengths which could be maintained and weaknesses which could lead to recommendations regarding the improvement of the documentation of the nursing care provided.

The first hypothesis: Documentation by nurses of the assessment component of the nursing process as measured by the Craig Audit Tool will be higher than 40%, was not accepted. The second hypothesis: Documentation of the planning component of the nursing process by nurses as measured by the Craig Audit Tool will be higher than 40%, was not accepted. The third hypothesis: Documentation of the implementation component of the nursing process by nurses as measured by the Craig Audit Tool will be higher than 40%, was accepted. The fourth hypothesis: Documentation by nurses of the evaluation component of the nursing process as measured by

the Craig Audit Tool will be higher than 40%, was also accepted. (Table 2)

TABLE 2

Percent Documentation for Four Components

	Achieved
Assessment	31.77%
Planning	26.38%
Implementation	44.72%*
Evaluation	48.05%*

*Meets minimal standards

The results achieved for each component of the nursing process reflect (Table 2) that the minimal standard of 40% as established by Craig, was not met in the assessment phase. The total score of the planning component was 26.38%, which did not meet the minimal standard. Both the implementation component and the evaluation component met minimal standards with the total score of 44.72% and 48.05% respectively.

A comparison of the documentation of the nursing process on records of patients discharged from specific nursing units are presented in Table 3:

TABLE 3

Percent Documentation for Four Components
Per Nursing Unit

Component	Psych	Med	RCU	ICU	LTC	Surg
Assessment	32.11	21.25	16.67	44.32*	64.77*	11.52
Plan	27.52	24.12	18.52	41.67*	34.72	11.71
Implementation	38.64	40.63*	43.25*	63.34*	48.75*	33.73
Evaluation	42.08*	42.50*	40.83*	60.00*	65.00*	37.86
Unit Mean	35.09	32.13	29.82	52.33*	53.31*	23.71

*Meets Minimal standards

Records from two out of six nursing units met minimal standards in assessment, ICU with 44.32% and LTC with 64.77%. ICU with 41.67% was the only unit where records met the minimal standards in the planning component. Records of the following four units achieved above the minimal standards in implementation, Medical with 40.63%, RCU with 43.25%, ICU with 63.34% and LTC with 48.75%. All units except the Surgery unit achieved above minimal standards in the evaluation component. Because three of the nursing units had fewer than ten records, unit comparison may not be statistically valid.

The number of records per nursing unit achieving scores in the ranges of excellent, good, fair, deficient and poor for the assessment, planning, implementation and evaluation components of the nursing process. In the assessment phase, two records were in the excellent range, three records in the good range, seven in the fair range, fifteen in the deficient range and thirty-three in the poor range. The planning component had two records in the excellent range, three in the good range, five in the fair range, fourteen in the deficient range, and thirty-six in the poor range. The implementation component had four records in the excellent range, seven in the good range, eighteen in the fair range, twenty-five in the deficient range and six in the poor range. The last component, evaluation, had four records in the excellent range, eight in the good range, twenty in the fair range, twenty-six in the deficient range and two in the poor range.

Results Related to Each Component of the Nursing Process

In order to fully appreciate the extent of the inter-relationships of these components and the inter-relationships of the results, one needs first to analyze and study each component as an individual entity. Each

component of the nursing process has a definite purpose and specific goals which are inter-related and inter-dependent. To omit any component interrupts the integrity of the nursing process.

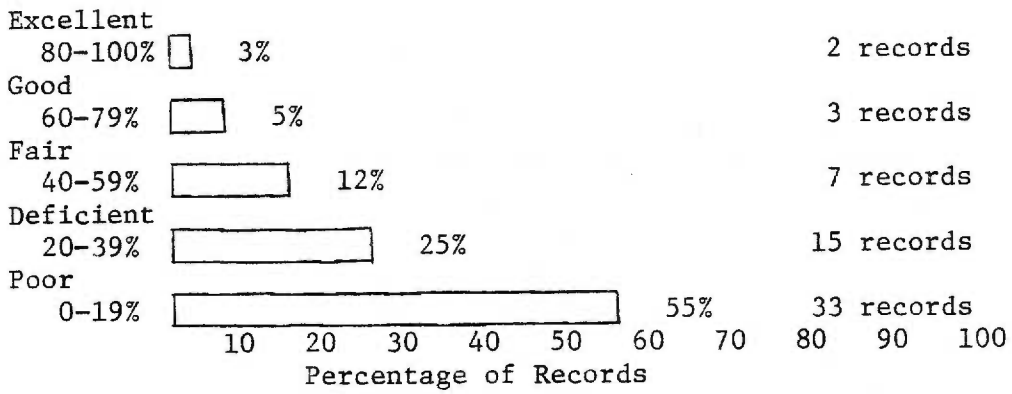
Assessment

In the assessment component, the percentage scores of the sixty records audited ranged from 3% to 55%. (Figure 1) Forty-eight, or 80% of the records were either in the deficient or poor range. Seven, or 12%, of the records were in the fair range; three or 5% of the records were in the good range, while two records or 3% were in the excellent range.

FIGURE 1

Percentage of All Records Achieving Scores in Ranges of Excellent, Good, Fair, Deficient, Poor

ASSESSMENT COMPONENT



Assessment is the collection of a data base followed by the formation of impressions of the patient's status or condition. The nurse concludes this phase with a nursing diagnosis which identifies an existing or potential health problem that nurses are qualified and licensed to treat.

According to Yura and Walsh (1978) making a nursing diagnosis re-

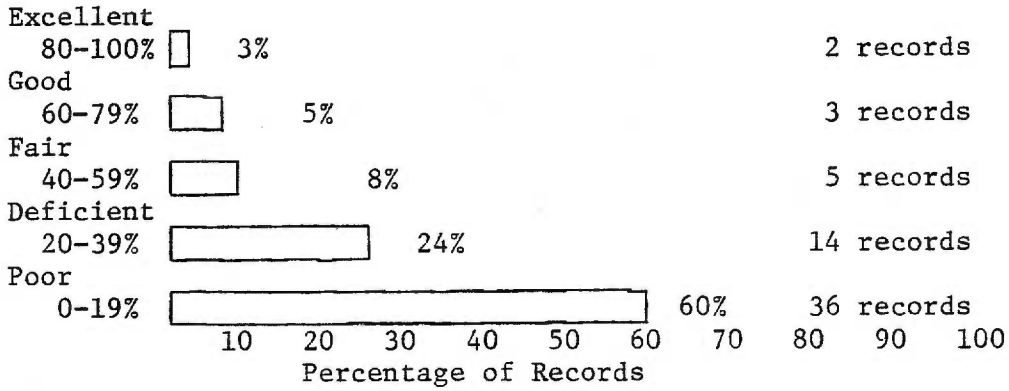
quires a high level of intellectual skill. They note that the nursing diagnosis is the most strategic aspect of the nursing process. Without it there is no reason to continue to other components of the process in an effort to solve a patient's problems; since there will be no basis for planning or intervention, or any basis for evaluative judgments about the patient's problems. If this concept is valid, then the assessment component is the most crucial and therefore, should reflect the highest score. However, in this study, the assessment component of the nursing process did not meet minimal standards on the sample records audited. For example, criteria in the deficient and poor range were documentation of present physical, social and emotional status; nursing diagnosis(es); and present occupation and history. Some speculations concerning the deficient criteria could be the absence of a systematic method or tool to document the nursing history, including physical, social and emotional status. Also, when patient problems were identified, they were most often stated as a medical diagnosis rather than a nursing diagnosis. Perhaps the present occupation and history were not addressed as in general, the population is elderly and many of these individuals have service-connected or occupational disabilities with physical and emotional handicaps.

In the planning component, the percentage scores of the sixty records audited ranged from 3% to 60%. (Figure 2) Fifty or 84% of the records were either in the deficient or poor range. Five or 8% of the records were in the fair range, three or 5% of the records were in the good range, and two or 3% or the records were in the excellent range.

FIGURE 2

Percentage of All Records Achieving Scores in Ranges of Excellent, Good, Fair, Deficient, Poor

PLANNING COMPONENT



The planning component of the nursing process, draws heavily on critical thinking and decision-making, and requires nursing judgment. In problem-solving, nurses have been didacticly prepared to identify the problem, explore solutions to the problem and proceed to implement the most expedient solution. However, they may not have been prepared to document in a retrievable manner this process of problem-solving.

In the planning phase, decisions are formulated with the patient and significant others, such as relatives and friends to develop expected outcomes based on the nursing diagnosis.

The criteria measuring documentation of the planning component that was deficient are as follows: family involved in palnning; plans included educational component; and long term goals were identified. The deficiency in this component may not necessarily be related to documentation, but rather due to the patient population where many veterans who do not have significant others, either live independently or in foster homes, boarding homes and nursing homes. Over 70%

of the records audited revealed that patients had previous hospitalization and may have been known from the past. Perhaps less information is documented when nurses have had previous contact with the patient. It may also be that since social workers have the primary responsibility at the study facility to complete the social data base, that nurses do not routinely document family involvement as a portion of the planning component. Another possibility is that nurses document their plan of care on the nursing care plan - which would not reveal if family were included in the planning of care. Likewise, nurses frequently provide care to resolve the immediate problem without making long range plans and therefore, long term goals are not being addressed even though a specific V.A. Form 2911, used exclusively for documentation by registered nurses, requires that long range goals be identified.

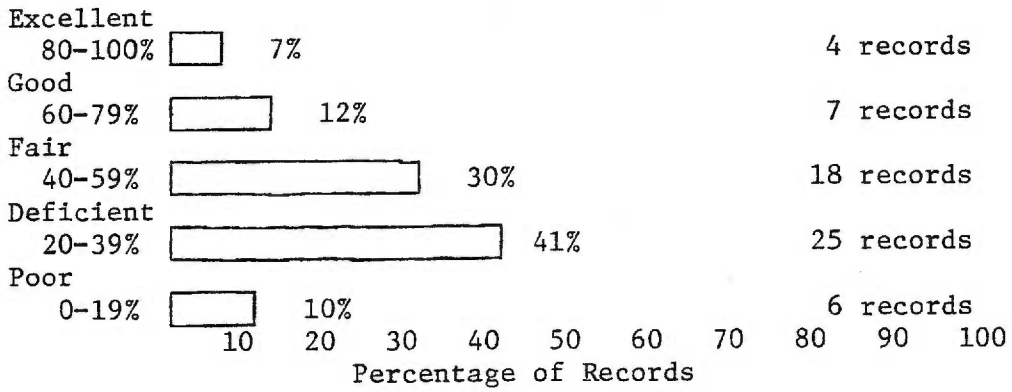
Implementation

According to the present study, while implementation, the third component of the nursing process, was above minimal standards, it fell within the fair range (Figure 3). Percentage scores of the sixty records audited ranged from 7 to 41. Thirty-one or 51% of the records were either in the deficient or poor range. Eighteen or 30% of the records were in the fair range, seven or 12% of the records were in the good range, and four or 7% of the records were in the excellent range.

FIGURE 3

Percentage of All Records Achieving Scores in Ranges of Excellent, Good, Fair, Deficient and Poor

IMPLEMENTATION COMPONENT



While the planning component of the nursing process is cognitive, implementation, the third component, is operative. It is the actual delivery of the prescribed nursing care. In this phase, the nurse may delegate responsibility for portions of the planned care. For example, at the study facility, the plan of care may be implemented by registered nurses, licensed practical nurses and nursing assistants. Some planned interventions can be carried out by the patient himself. It is the responsibility of the registered nurse to coordinate comprehensively the implementation of the nursing care. The implementation component ends when the nursing intervention is complete and has been documented in the clinical record. A way to determine if this phase of care has been completed is to review the documentation in the clinical record.

The implementation phase of the nursing process, according to Yura and Walsh (1978), draws heavily on the intellectual, interpersonal, and technical skills of the nurse. Decision making, observation and com-

munication are also skills required for the delivery of care.

Although the implementation component was above minimal standards, 41% of the records audited were deficient in this component. Some audit criteria that were not addressed in the nurses' documentation were communication skills, nursing diagnoses followed, health promotion and counselling and guidance. Perhaps this deficient rating may be due to the use of medical diagnoses instead of nursing diagnoses. Secondly, most records did not reflect the use of communication skills and there was no documentation that the nurse and the patient had developed a therapeutic relationship. In addition, in over 70% of the records, health education with preventive teaching was not recorded. Nurses traditionally have prided themselves on the delivery of health care, and this raises the question, "Why is this care not documented?" One reason may be that despite implementation of problem oriented medical records, nurses do not have an organized comprehensive method of charting, which would increase the completeness, accuracy and legibility of documentation without an increase in workload.

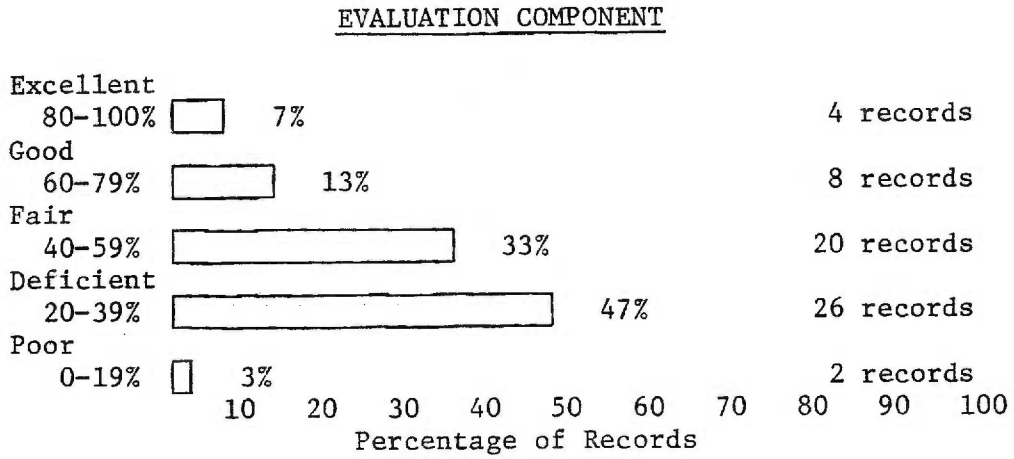
Evaluation

One would think that if assessment and planning were within the deficient range, and implementation was barely within the fair range, that the evaluation component would also be in line with those components. However, the data indicate that the evaluation component was above minimal standards, in the fair range, and received the highest over-all percentage (Figure 4). The evaluation component scores of the sixty records audited ranged from 3% to 48%. Twenty-eight or 47% of the records were either in the deficient or poor range. Twenty or 33% of the records were in the fair range, eight or 13% of the records were

in the good range and four or 7% of the records were in the excellent range.

FIGURE 4

Percentage of All Records Achieving Scores in Ranges of Excellent, Good, Fair, Deficient and Poor



Evaluation is the final phase of the nursing process. It is the intellectual process of determining if specific nursing interventions, based on pre-determined expected outcomes, were effective. Yura and Walsh (1978) state that evaluation, like assessment and planning, are concurrent and recurrent with other components. Evaluating the effect of actions during and after the implementation phase, determines the patient's response and the extent to which immediate and long range goals are achieved. By evaluating nursing action, the nurse demonstrates responsibility and accountability for nursing actions, discontinues those actions that are not helpful, pinpoints any omissions which occurred during the other phases, and continues actions that are effective.

The criteria used to measure the evaluative phase included evidence of subjective information, objective information, revision of nursing care plans, the nurses involvement in the evaluation, and signatures and dates on all nursing entries. As might be expected, nurses in general were more familiar with the criteria measured in the evaluation component than the criteria in the other three phases, and that could explain why the evaluation scores were the highest. Nurses have been prepared academically to evaluate the effects of nursing actions on concrete observable behaviors such as patient's appearance, blood pressure and temperature and to update nursing care plans. This documentation may also be facilitated by the use of problem oriented medical recording, use of flow sheets for vital signs, and Nursing Service policy that the date be written when evaluating nursing care plans. Nursing Service policy also mandates that nursing entries be signed and dated.

The total scores for the assessment and the planning components were deficient, and implementation and evaluation components were fair. The author asks the question, "If the assessment and planning scores had been fair, would the implementation and evaluation components be excellent?" Recently acquired unpublished data over a three year period from Craig indicates a pattern wherein the assessment and planning component consistently continue to be lower than the implementation and evaluation components. (See Appendix D)

Interpretation of the Documentation Ranges

The number of total records in the excellent, good, fair, deficient and poor range in the documentation of the combined components of the nursing process is reflected in Table 4. Each of the sixty records was

given a total score which consisted of the sum of the four nursing process components. The scores were placed in the ranges of poor through excellent. Nineteen of the sixty records were in the poor range, twenty-seven of the total records were in the deficient range, eight of the total records were in the fair range, five of the total records were in the good range and one record out of sixty was in the excellent range.

TABLE 4

Number of the Total Records Achieving Scores in Ranges of Excellent, Good, Fair, Deficient and Poor

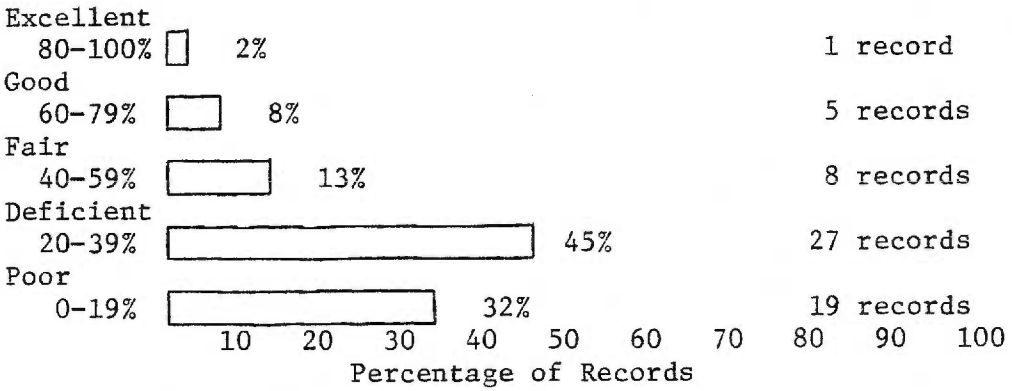
COMBINED COMPONENTS

	Poor	Deficient	Fair	Good	Excellent
Medicine	7	8	3	1	1
Psych	6	4	3	3	
RCU	1	4	1		
Surg	5	8	1		
LTC		2			
ICU		1		1	
Total	19	27	8	5	1

FIGURE 5

Total Percentages of Records Achieving Scores in Ranges of Excellent, Good, Fair, Deficient and Poor

COMBINED COMPONENTS



The total percentage scores in the combined components of the nursing process (Figure 5) ranged from 2% to 45%. Seventy-seven percent of the records were either deficient or poor, eight, or 13% of the records were fair, five, or 8% of the records were good, and one, or 2% of the records was excellent.

TABLE 5

Comparison of Results of Craig's Original Findings

Nursing Process Component	Study Results	Craig's Results	Difference Between Studies
Assessment	31.77	26	-5.77
Plan	26.38	30	+3.62
Implementation	44.72	39	+5.73
Evaluation	48.05	42	+6.05

The results of this study as compared to Craig's original findings are: Assessment - Craig 26%, this study 31.77%; Planning - Craig 30%, this study 26.38%; Implementation - Craig 39%, this study 44.72%; Evaluation - Craig 42%, this study 48.05% (Table 5).

According to this study on the sixty records audited, the documentation of the nursing process by registered nurses at the study facility ranged between deficient and fair on 72% of the records audited. This may have been for various reasons, including a lack of nursing assessment tools in the patient records, a lack of distinct definition of responsibility for collecting psychosocial data, the educational preparation of the nurse, and the individual responsibility of the nurse to develop skill in using and documenting the nursing process.

Institutions such as the study facility have an expectation that nurses use and document the nursing process. It is encumbent upon the

facility to teach not only the process, but also its documentation, followed by frequent cart reviews based on specific criteria to determine compliance of those nurses completing their educational program before 1981.

Just as the nurse's philosophy, education and experience influence the individual nurse's ability to utilize the nursing process, so will these significantly affect documentation of the process.

Limitations

The study was limited by the audit instrument itself and the subjective view of the raters. In addition, due to attrition, it may be that nurses currently practicing at the study facility have not had formalized facility-based training in the use and documentation of the nursing process. It may also be at the study facility nurses have not become familiar with expectations of their documentation. This tool measured nurse's documentation against criteria with which the nurses were not familiar. Most of the registered nurses at the study facility completed their education prior to the integration of the nursing process into nursing curricula, and have become aware of this model through attendance at seminars, workshops or current literature. Also, prior to this study, Nursing Service had no official policy stating that the nursing process was the basis for nursing performance at the study facility. Therefore, the validity of generalizing these findings to other facilities may be questionable.

CHAPTER 4

SUMMARY AND RECOMMENDATIONS

This evaluative research study was completed as a portion of a comprehensive plan for the study facility to meet the requirements of the Joint Commission on Accreditation of Hospitals pertinent to documentation of nursing care. The purpose was to provide information concerning the documentation by registered nurses of the components of the nursing process on the patient record.

The Craig Audit Tool (1978) was selected as the instrument to determine if the nursing process is documented by registered nurses through the appraisal of the nurse's notes in the patient's record. This tool was designed to measure documentation of the four components of the nursing process: assessment, planning, implementation and evaluation. The audit tool established a score of forty percent or above as the minimal acceptable standard for documentation of the nursing process by registered nurses. This audit allowed the interpreter to judge poor, deficient, fair, good and excellent nursing care as documented on the discharged patient record.

A pilot study was conducted to provide three raters with audit tool familiarity and to generate data to establish between-rater reliability. Reliability testing followed Craig's (1978) recommendations, which also were in agreement with Phaneuf's (1976) suggestions.

The records of sixty patients discharged during a one month period were selected for auditing. Records were selected by random process,

with the number of records from each nursing unit based on the unit's total discharge rate for that month.

Despite the fact that there is general agreement within the nursing profession that the nursing process is the core and essence of nursing, and central to all nursing actions, there are indications that registered nurses are not documenting the utilization of this approach in their work settings. To determine whether registered nurses are documenting the nursing process on the nurse's notes, four hypotheses were tested. The conclusions drawn from this study according to Craig Audit Tool measurements are: The first hypothesis: Documentation by nurses of the assessment component of the nursing process and measured by the Craig Audit Tool will be higher than 40%, was rejected (31.77%). The second hypothesis: Documentation of the planning component of the nursing process by nurses as measured by the Craig Audit Tool will be higher than 40%, was rejected (26.38%). The third hypothesis: Documentation of the implementation component of the nursing process by nurses as measured by the Craig Audit Tool will be higher than 40%, was accepted (44.72%). The fourth hypothesis: Documentation by nurses of the evaluation component of the nursing process as measured by the Craig Audit Tool will be higher than 40%, was also accepted (48.05%).

The conclusions drawn from this study are that in 90% of the records audited documentation of the nursing process by registered nurses ranged between poor, deficient and fair, while the remaining 10% were in the good and excellent range. These results identified areas of strengths which could be maintained and weaknesses which could lead to recommendations regarding the improvement of the documentation of the

nursing care provided.

This study may have two implications for nursing. One is that individual nurses and/or this facility may have not accepted the nursing process as the theoretical model for practice and also that nurses do not manifest the skill in documenting the use of the nursing process in a systematic, organized way.

Recommendations

The following recommendations were made to the Chief, Nursing Service to facilitate improvement of the level of documentation of the components of the nursing process by registered nurses at the study facility.

1. That a study be initiated to compare the educational preparation of the registered nurse with the level of documentation as measured by Craig's Audit Tool.

2. That Nursing Service adopt the list of nursing diagnoses accepted at the Fourth National Conference for use in documentation by registered nurses.

3. That Nursing Service develop a standardized nursing assessment tool to be utilized by the registered nurses when documenting the nursing assessment on admissions.

4. That this study be replicated to determine nurses' level of documentation after completion of a six-hour workshop on the nursing process, and documentation of the nursing process.

5. That this study be replicated with an equal number of discharged records from each nursing unit, facilitating comparison of nurses' documentation by specialty areas.

While this study was in progress and deficiencies were identified, Nursing Service administration immediately developed a policy to identify the nursing process model as the basis for nursing practice at this facility. A six-hour workshop on the nursing process and documentation of the nursing process was also presented to all registered nurses at the study facility.

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DEFINITION OF TERMS

The definitions of significant terms in this study are as follows:

1. Nursing Process: Yura & Walsh (1980)
   Is an orderly, systematic manner of determining the patient's problems, making plans to solve them, initiating the plans and evaluating the extent to which the plans were effective in resolving the problem identified.

2. Subjective Data: Weed (1971)
   Is the qualitative and quantitative description of the symptoms appropriate to the identified patient problem.

3. Objective Data:
   Is the factual information resulting from the nurse's observations pertinent to the given problem.

4. Assessment: Murray & Zenter (1975)
   Is the act of reviewing a situation for the purpose of diagnosing the patient's problem.

5. Implementation:
   Is the initiation and completion of the nursing action necessary to accomplish defined goal.

6. Planning:
   Is the determination of what can be done to assist the patient; it involves setting goals, judging priorities, and designing methods to resolve problems.

7. Evaluation:
   Is the act of qualifying if specific nursing interventions, based on achievement of expected outcomes, were effective.

8. Registered Nurse: (R.N.)
   Is an individual, currently licensed as a registered nurse in any state or territory of the U.S.A. on the staff at Roseburg Veterans Administration Medical Center.

9. Nursing Diagnosis: Gebbie & Lavin (1975)
   Is a classification system that may be a singular patient problem or plural patient problem depending on the health status, deprivation or alterations the patient has in meeting basic human needs.

   Thomas & Coombs (1975)
   Is a statement of a conclusion resulting from a recognition of a pattern derived from a nursing investigation of the patient.

10. Veterans Administration Medical Center, Roseburg, Oregon: (VAMC)
Is a government owned medical center under the auspices of the Veterans Administration that delivers health care to U.S.A. veterans and certain qualifying allies.

11. Joint Commission of Hospital Accreditation: (JCAH)
Is a private organization created by and composed of health care professionals. In its accreditation process it assumes three primary responsibilities - development of standards, application of standards during on-site survey and awarding accreditation to facilities and programs that meet JCAH's standards.

12. Nursing Order/Strategy/Prescription/Action:
Is a specific statement of independent nursing action, based on objectives, relative to an established nursing diagnosis; designated actions that will most likely effect a change in the patient's behavior/status; plan of independent nursing managements.

13. Outcome/Goal/Objective:
Is a projected patient behavior or clinical manifestations which represents resolution, progress toward resolution or prevention of an unusual problem.

14. Problem Oriented Medical Records: (POMR)
Is a method of documentation that focuses on the problems of the patient, instead of the source of information.

15. Gain and Loss Sheet:
Is a document prepared daily reporting all gains and losses within the preceding 24 hour period. This includes gains (admissions) and losses (releases from in-patient care).

Department of Medicine and Surgery
Washington, D.C. 20420

44.

Veterans Administration

APPENDIX A

IL 11-81-15

Route & Initial
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Action
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May 4, 1981

PROFESSIONAL SERVICES LETTER

TO: Directors, VA Medical Centers, Medical and Regional Office Centers, Outpatient Clinics and Regional Offices with Outpatient Clinics

SUBJ: Medical Record Deficiencies

1. During the past year, a high proportion of external review reports (e.g., JCAH, SERP and Inspector General) have consistently and often severely criticized many of our facilities for the lack of adequate documentation in the medical record.

2. Since medical record documentation is a major compliance factor reviewed by the JCAH, some of our facilities have even had their accreditation status adversely affected because of poor medical record documentation.

3. In many instances, this deficiency is not new, but a repeat of an identical deficiency listed on a prior survey or even multiple surveys.

4. It is the responsibility of the Chief of Staff and the Clinical Executive Board to see that appropriate mechanisms are established for monitoring and correcting medical record deficiencies.

5. It is suggested that appropriate action be taken to assure that this deficiency is not listed in future external review reports on your facility.

[redacted]

CARL W. HUGHES, M.D.
Assistant Chief Medical Director
for Professional Services

Distribution: COB: (10) only plus (11) 15
SS (101B1) FSB: MA, OC and OCRO
EX: Boxes 60, 44 and 52-1 ea.

617845-P

In Reply Refer To: 11F

APPENDIX B

CRAIG AUDIT TOOL

Scoring:

Put appropriate score in specified box.

EXCELLENT	(E)	All information is documented	Score 4
GOOD	(G)	Most information documented	Score 3
FAIR	(F)	Some information documented	Score 2
DEFICIENT	(D)	Some indication of attempt to document	Score 1
POOR	(P)	No information or attempt to obtain information	Score 0
NOT APPLICABLE	N/A	Place check in box	✓

ASSESSMENT

Age of Patient ____

	SCORE					
	E 4	G 3	F 2	D 1	P 0	N/A ✓
Individual:						
1. Present physical status and history.	( )	( )	( )	( )	( )	( )
2. Present social status and history.	( )	( )	( )	( )	( )	( )
3. Present emotional status and history.	( )	( )	( )	( )	( )	( )
4. Present occupation and history.	( )	( )	( )	( )	( )	( )
5. Individual's perception of situation.	( )	( )	( )	( )	( )	( )
6. Individual strengths.	( )	( )	( )	( )	( )	( )
7. Individual limitations.	( )	( )	( )	( )	( )	( )
Total individual	==	==	==	==	==	==
Nursing Diagnosis:						
8. Nursing diagnosis(es) documented.	( )	( )	( )	( )	( )	( )
9. Nursing diagnoses based on data base.	( )	( )	( )	( )	( )	( )
10. Nursing diagnoses complete.	( )	( )	( )	( )	( )	( )
11. Priorities established for nursing diagnoses.	( )	( )	( )	( )	( )	( )
Total Nursing Diagnoses	==	==	==	==	==	==

PLANNING

		SCORE					
		E 4	G 3	F 2	D 1	P 0	N/A ✓
12.	Individual involved in planning.	( )	( )	( )	( )	( )	( )
13.	Family involved in planning.	( )	( )	( )	( )	( )	( )
14.	Initial Plan.	( )	( )	( )	( )	( )	( )
15.	Plans encouraged independence.	( )	( )	( )	( )	( )	( )
16.	Plans reflected disease process.	( )	( )	( )	( )	( )	( )
17.	Life stages.	( )	( )	( )	( )	( )	( )
18.	Plans included educational component.	( )	( )	( )	( )	( )	( )
19.	Plans included health promotion/anticipatory guidance.	( )	( )	( )	( )	( )	( )
20.	Plans were co-ordinated with or complementary to care provided by other health workers.	( )	( )	( )	( )	( )	( )
	Total Planning	==	==	==	==	==	==

IMPLEMENTATION

		SCORE					
		E 4	G 3	F 2	D 1	P 0	N/A ✓
21.	Nursing care plans followed by appropriate action.	( )	( )	( )	( )	( )	( )
22.	All nursing diagnoses followed.	( )	( )	( )	( )	( )	( )
23.	Nursing skills documented.	( )	( )	( )	( )	( )	( )
24.	Nursing skills documented within nurse's competence.	( )	( )	( )	( )	( )	( )
25.	Communication skills.	( )	( )	( )	( )	( )	( )
26.	Nursing actions.	( )	( )	( )	( )	( )	( )
27.	Counselling and guidance.	( )	( )	( )	( )	( )	( )
28.	Health promotion/ anticipatory guidance.	( )	( )	( )	( )	( )	( )
29.	Technical skills.	( )	( )	( )	( )	( )	( )
30.	Referrals.	( )	( )	( )	( )	( )	( )
31.	Time lapse.	( )	( )	( )	( )	( )	( )
	Total Implementation	==	==	==	==	==	==

EVALUATION

	SCORE					
	E 4	G 3	F 2	D 1	P 0	N/A ✓
32. Subjective information.	( )	( )	( )	( )	( )	( )
33. Objective information.	( )	( )	( )	( )	( )	( )
34. Nursing care plans updated.	( )	( )	( )	( )	( )	( )
35. Individual/family involved in evaluation.	( )	( )	( )	( )	( )	( )
Total Evaluation	==	==	==	==	==	==

SCORE for:

Assessment (1 - 11) ____ Implementation (21 - 31) ____

Planning (12 - 20) ____ Evaluation (32 - 36) ____

TOTAL SCORE: _____

TOTAL NOT APPLICABLE _____

Circle appropriate comment:

$$\frac{\text{Total score obtained on audit}}{\text{Total Perfect Audit Score - number of criterion measures not applicable x 4}} \times 100 = \%$$

measure of quality of care

Excellent 80 - 100%

Good 60 - 79%

Fair 40 - 59%

Deficient 20 - 39%

Poor 0 - 19%

COMMENTS:

_____

_____

RECOMMENDATIONS:

_____

_____

_____

Signature of Auditor

Date _____

APPENDIX B

CRAIG AUDIT CRITERIA/STANDARDS

ASSESSMENT

Individual:

1. Criterion: Present Physical Status and History:

   Standard: The recording should include: a review of body system with illnesses, operations, or concerns.

2. Criterion: Present Social Status and History:

   Standard: The recording should include: the individual's ability to relate to family members, peers and persons in authority. Concerns should be noted if there is a lack of individual, or group involvement.

3. Criterion: Present Emotional Status and History:

   Standard: Recording should include: some evidence as to the individual's feelings of confidence and self-worth, his emotional stability, and the individual's ability to cope with the activities of daily living and stress.

4. Criterion: Present Occupation and History:

   Standard: Recording should include: present occupational status and type of work, job history and any problems which relate to unsuitable employment, or frequent job changes.

5. Criterion: Individual's Perception of the Situation:

   Standard: Recording should include: mention of how the individual concerned assesses the situation. If a child is involved where a response is not feasible, the parent's assessment of the situation can be accepted.

6. Criterion: Individual Strengths:

   Standard: The recording should include: the attitudes of the individual on which the nurse can rely in problem solving.

7. Criterion: Individual Limitations:

   Standard: The recording should include: the attributes of the individual which will retard or inhibit problem solving.

Nursing Diagnoses:

8. Criterion: Nursing Diagnosis(es):

   Standard: There is a diagnosis(es) in the record.

9. Criterion: Nursing Diagnoses Based on Data Base:

   Standard: There is evidence in the data base which identifies the reason for establishing the nursing diagnoses.

10. Criterion: Nursing Diagnoses Complete:

    Standard: All nurses diagnoses which can be identified in the data base have been established.

11. Criterion: Priorities Established for Nursing Diagnoses:

    Standard: There is evidence where there are a number of nursing diagnoses that the nurse has grouped these according to relatedness by stating in her plan for intention of dealing with the related items and also that the nurse has set priorities by using a specific time frame for intervention or a statement of deferral of intervention with reason.

PLANNING

12. Criterion: Individual Involved in Planning:

    Standard: There is evidence that the individual was involved in the planning process.

13. Criterion: Family Involved in Planning:

    Standard: There is evidence that the family was involved in the planning process.

14. Criterion: Initial Plan:

    Standard: There is an initial plan which identifies the long term goals for each nursing diagnosis established.

15. Criterion: Plans Encouraged Independence:

    Standard: The nursing care plans encouraged as much action from the individual/family as each was capable.

16. Criterion: Plans Reflected Physiology of Disease Process:

    Standard: The nursing care plan was based on knowledge of the disease process and/or developmental lag and the individual/family response(s).

17. Criterion: Life Stages:

    Standard: The nursing care plan took into account the individual/family stages of development which affected the situation and the problem solving approach.

18. Criterion: Plans Included Educational Component:

    Standard: There is evidence that educational opportunities related to the disease process were recognized and utilized by the nurse.

19. Criterion: Plans Included Health Promotion and/or Anticipatory Guidance:

    Standard: There is evidence that the nurse anticipated some of the individual/family responses by offering preventive education. Plans include promotion of health by life styles as needed.

20. Criterion: Plans were Co-ordinated with, or Complementary to, Care Provided by Other Health Workers:

    Standard: There is evidence that the plans took into account the impact of other health and social personnel who were involved with the individual/family.

IMPLEMENTATION

21. Criterion: Nursing Care Plans Followed by Appropriate Action:

    Standard: There is evidence that the nurse carried out her plan or documented reasons why it could not be completed.

22. Criterion: All Nursing Diagnoses Followed:

    Standard: All nursing diagnoses were followed.

23. Criterion: Nursing Skills Documented:

    Standard: The nursing interventions are documented and not only the patient responses, or the activities of daily living.

24. Criterion: Nursing Skills Documented Within Nurse's Competence:

Standard: Nursing skills documented are within the level of competence of the nurse.

25. Criterion: Communication Skills:

Standard: Communications skills show evidence that the nurse and individual/family have developed a therapeutic relationship.

26. Criterion: Nursing Actions:

Standard: Nursing actions documented are directed toward the achievement the short and long term goals which have been identified.

27. Criterion: Counselling and Guidance:

Standard: Counselling and guidance reflects the nurse's understanding of normal development, physical, social, emotional and the physiology of the disease process.

28. Criterion: Health Promotion/Anticipatory Guidance:

Standard: Health education promoted healthy life style choices and anticipated individual/family responses by preventive education.

29. Criterion: Technical Skills:

Standard: Technical skills are documented with results when appropriate, e.g., blood pressure measurement, pulse rate.

30. Criterion: Referrals:

Standard: There is evidence that referrals have been instituted to other health and social agencies when needed.

31. Criterion: Time Lapse:

Standard: The interval between nursing diagnoses and implementation of nursing care plans is appropriate.

EVALUATION

32. Criterion: Subjective Information:

Standard: There is documented the individual/family assessment of nursing intervention and progress in the situation on an ongoing basis.

33. Criterion: Objective Information:

    Standard: There is documentation of significant objective measurements, e.g., appearance, blood pressure, temperature, etc., when situation indicates need.

34. Criterion: Nursing Care Plans Updated:

    Standard: There is evidence that nursing care plans have been changed as subjective and objective information were assessed.

35. Criterion: Individual/Family Involved in Evaluation:

    Standard: There is evidence that the individual/family have been included in periodic evaluations of the total situation for the renegotiation of a contract or termination of nursing care.

36. Criterion: All Entries Signed and Dated:

    Standard: All entries signed and dated with title of health worker included.

Veterans Administration

Memorandum

Date: March 18, 1981

To: Chairperson, Medical Center (118)
Research Committee

~~From~~ THRU: Chairperson, Nursing Service(118)
Research Committee

SUBJ: Descriptive retrospective audit study

1. Request permission to conduct a descriptive retrospective audit study titled "Documentation of the Nursing Process in the Discharged Patient Record." This retrospective audit will be conducted on sixty records of veterans discharged during the month of March.

2. This audit will complete the University of Oregon Health Sciences Center Thesis requirements. The completion of a thesis is in partial fulfillment of a Masters in Mental Health/Psychiatric Nursing.

Thank you.

[redacted]

SHIRLEY PURCELL, R.N.
Supervisor, Nursing Home Care Unit(181)

Veterans Administration

Memorandum

Date: April 22, 1981

To: Shirley Purcell, RN
Supervisor, NHCU

Subj: Audit of Medical Records

1. Your request to collect data at this facility, by retrospective audit of 60 medical records, has been recommended and approved by this committee and subsequently approved by the Chief, Nursing Service. Such audit requires no further approval.

2. For the veteran patient's records and for this facility, complete anonymity is required.

3. This committee requests that you share with us the results of your audit.

4. You are commended for your efforts to scientifically identify areas for improvement of professional nursing practice.

[redacted]

C. HUGHES, RN
Chairperson,
Nursing Service Study and Research Committee

1428 Old Garden Valley
Roseburg, Oregon 97470
February 25, 1981

Dorothy Craig, M.Sc.N
Director of Nursing
Halton Regional Health Unit
1151 Bronte Road
Oakville, Ontario L6J6E1

Dear Ms. Craig:

I am a graduate student majoring in Mental Health Nursing at the University of Oregon, Health Sciences Center, Portland, Oregon.

I would like to request your permission to copy and use the Craig Audit Tool (your construction of which was reported in The Development of a Nursing Audit Tool Thesis, 1978) in my thesis.

The title of my study is "A Survey of Nurses' Documentation of the Nursing Process in Records of Discharged Patients."

Thank you for your attention to this request.

Sincerely,

Shirley Purcell

HALTON REGIONAL HEALTH UNIT

BRANCH OFFICES:

GEORGETOWN -
1A PRINCESS ANNE DRIVE
L7G 4W4 877-2238

MILTON -
53 BROWN STREET
L9T 2C5 878-7245

HEAD OFFICE

OAKVILLE -
P.O. BOX 7000
1151 BRONTE ROAD
L6J 6E1 827-2151

81 03 25

Ms. Shirley Purcell,
1428 Old Garden Valley,
Roseburg,
Oregan 97470.

Dear Ms. Purcell:

I hereby give my permission for you to copy and use the Craig Audit Tool in your survey.

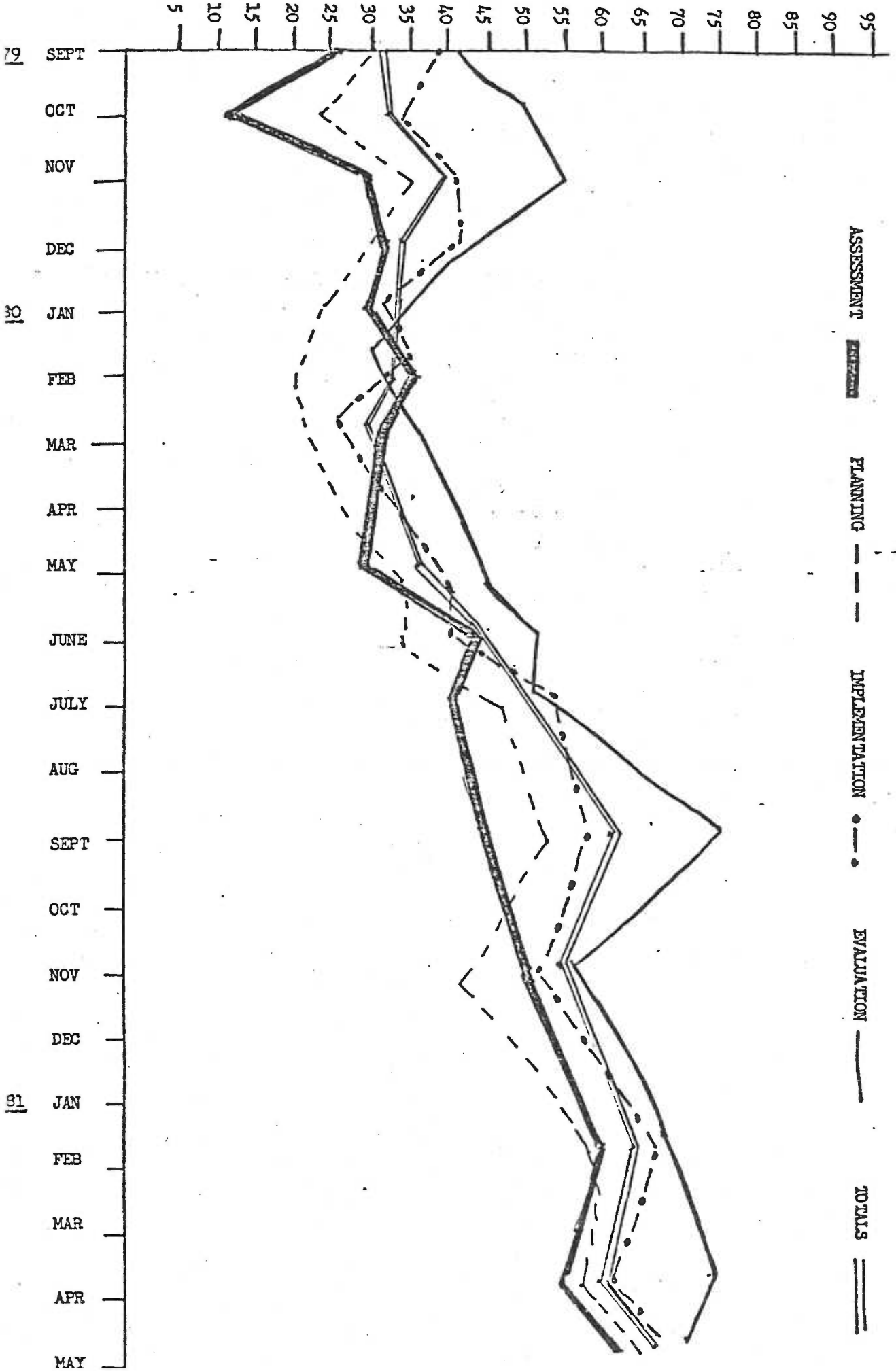
Sincerely,

[redacted]

(Miss) Dorothy Craig,
Director of Nursing.

/mc

APPENDIX D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ASSESSMENT
PLANNING
IMPLEMENTATION
EVALUATION
TOTALS

AN ABSTRACT OF THE THESIS OF

SHIRLEY PURCELL

For the MASTER OF NURSING

Date of Receiving this Degree: June 1982

Title: DOCUMENTATION BY NURSES OF THE NURSING PROCESS IN THE DISCHARGED PATIENT RECORD

Approved: _____
Florence Hardesty, R.N., Ph.D., Thesis Advisor

The purpose of this evaluative research project was to determine if registered nurses are documenting the nursing process on the nurse's notes in the patient record.

There is general agreement within the nursing profession that the nursing process is the core and essence of nursing, central to all nursing actions and applicable within any frame of reference, any concept, theory or philosophy. Despite the fact that the nursing process has become an essential part of nursing practice, there are indications that some registered nurses are not utilizing this approach consistently in their work setting. When the nursing process is documented on the patient's record, it reflects the care given by the nurse. The nursing audit is one mechanism through which documentation by the registered nurse of the nursing process on the patient record can be assessed.

The Craig Audit Tool (1978) was selected as the instrument to deter-

mine if the nursing process is documented by registered nurses through the appraisal of the nurse's notes in the discharged patient's records. This tool is designed to measure the four components of the nursing process and establishes a score of forty percent or above as the minimal acceptable standard for documentation of the nursing process by registered nurses. This tool allows the interpreter to judge poor, deficient, fair, good and excellent nursing care as documented on the discharged patient records.

1. The conclusions drawn from this study according to Craig's Audit Tool measurements are that in 90% of the records audited, documentation of the nursing process by registered nurses ranged between poor, deficient and fair, the remaining 10% were in the good and excellent range.

2. Documentation of the assessment and planning components were below the minimal acceptable standards, implementation and evaluation components were above the standards as established by Craig's Audit Tool.

These results identified areas of strengths to be maintained and weaknesses which could lead to recommendations regarding the improvement of the documentation of the nursing care provided.