EVALUATION OF PROBLEM-ORIENTED CHARTING

by
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A FIELD STUDY

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Master of Nursing

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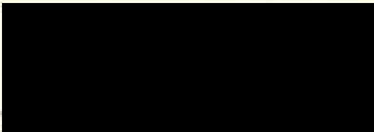

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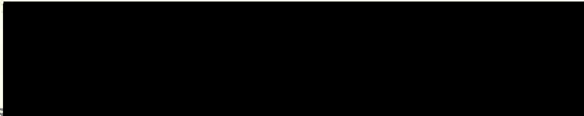

John M. Brookhart, Ph.D., Chairman Graduate Council

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My husband, Dave, who has been so understanding through it all.

j.a.j.

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CHAPTER I

INTRODUCTION

This study was intended to determine if problem-oriented charting, using the subjective, objective, assessment, and plan format, by nurses, would give more evidence of observations made and nursing care rendered than narrative summary charting.

Nursing care has been defined as the continuous process of assessing, planning, implementing, and evaluating activity that effects a change in the patient's health needs (1 3, 4, 5, 11, 16). Professional nurses are responsible for this process as well as for documenting on the patient's health care record all pertinent information that validates the skilled care given. What has been recorded reflects what has been done. If skilled nursing care is not recorded, we cannot expect physicians, and other team members to assume it was given. (13)

Documentation of nursing care is valuable not only to the nurse in planning and evaluating the care she gives but also to others on the health team for continuity of care and dialogue between professionals. (13, 14) Narrative summary charting records the presence of indicators of problems by identifying conditions and verifying the occurrence of events and observations within a time dimension. It provides a cumulative record which shows in sequence vital signs, descriptive activity, and the patient's condition in a given period of time. (3)

The content of the nurse's recordings provides the baseline for future observations and comparisons but only if they are accurate in relating the patient's problems. Most nurses can verbally account for the patient's need for care, but what they write on the patient's chart does not demonstrate this ability.

Factors inhibiting and facilitating the recording of skilled nursing care are apparent to professional nurses. Facilitating factors may be, first, the nurse is aware of her nursing responsibility and is concerned about the needs of the patient; second, the nurse is aware of the continuing nursing process and the use of the nursing record to reflect change in the patient's health needs; and, third, the nurse is aware of her need for legal documentation of her actions. (37, 44, 46, 67) Inhibiting factors might be, first, charting is not usually done concurrently with observations. Most often the charting is done later. And, pertinent observations may be omitted when drastic changes take place in the patient's condition. Second, the act of charting holds low priority for the nurse; the actual nursing care provision has high priority. Too often sufficient time is not available for both delivery and documentation of care so the nurse establishing priorities, skimps on the charting rather than on the nursing care. Third, the lack of use of the nurse's recordings by colleagues has led to the assumption that the notes have little value. And finally, attempts to omit repetitive or meaningless recordings have sometimes resulted in no recording at all.

The charting format, however, must reflect the patient's need for skilled care and that he did receive it. (6, 10, 13, 14) To the end of

producing more meaningful records, Lawrence L. Weed has suggested orienting the entire health care recording system as well as nurse's notes toward the patient's individual problems. Lawrence L. Weed states that "nurses notes...should not be separate parts of a medical record but should themselves be progress notes.."(15) relating to the patient's problems. (7, 10)

Problem-oriented charting is a systematic organized method of identifying patients' problems for patient management. The patient's problems are formulated from a data base established by the nursing history, the admitting examination, and laboratory findings. The problem list is an organized list of all problems pertaining to the patient, identified and titled. Each problem is numbered. Listing of the problems leads logically to a thoughtful survey of the patient's needs and their interrelationships. It also leads the nurse to assess and evaluate the patient's care in relation to his problems at the time most appropriate to the patient. (2)

The four phases of dealing with a specific numbered problem on a problem list are (a) subjective information related by the patient and/or significant others, (b) objective data pertaining to physiology, psychology, or laboratory values, (c) nursing assessment or analysis, and (d) planning how to solve, further define, prevent or monitor the problem. (This is also called a nursing order.)

Nursing care is given on the basis of problems identified and subsequent nursing care plans formulated. New problems are added as they are identified. Each charting entry is correlated with a patient problem. The nurse identifies subjective data from the patient

or relates a pertinent observation. An assessment is made and the plan of action formulated or evaluated. Continuity of care among professionals is facilitated because the nurse's charting refers to specific patient problems and is integrated with the medical record. Ongoing evaluation as a part of professional accountability can readily be made by use of an audit tool to review the health care record charting.

The rationale for use of the patient's chart as the source of information in auditing is that the chart is a service instrument essential to the safety of the patient and the management of his care. It also serves as a major means of communication between the various professionals involved in the care. In addition, recording on the chart is a function of nurses as well as of the doctor. It provides legal documentation of care provided. And, the chart is easily available to authorized nurses for the purpose of auditing. However, the audit does not reveal the actual nursing care performance. It only evaluates the nursing process that is recorded. (12)

There is a definite need for consistent, meaningful documentation of observations made and skilled nursing care rendered by professional nurses. (2, 6, 10, 12, 13, 14) This is of concern to the nursing profession. Charting has been the focus of inservice and continuing education programs in order to improve the nurses' recording abilities.

One of the new methods for improving recording is the problem-oriented charting method. In order to determine if recording of observations and nursing care was improving with use of problem-

oriented charting an audit was conducted. For the purpose of this study problem-oriented charting was compared to narrative summary charting to see if there would be any difference in the recorded evidence of observations made and nursing care rendered.

CHAPTER II

METHODOLOGY

Problem-oriented recording was first introduced to the private teaching hospital used in this study, by medical residents in 1972. On their rotations to the four medical units they began to utilize the problem list and the numbered progress notes. The nursing staff on the medical units were able to observe this recording system. In the Winter of 1973, the nursing inservice education department conducted an instructional program. The staff nurses of the medical units were taught how to implement problem-oriented charting on the nurse's notes. The new recording system had only been in use by the staff nursing personnel for two months when this study was undertaken.

Closed patient health care records were chosen for audit. They were selected by a medical librarian in the medical records department of this 490 bed private teaching hospital. The problem list of each record included a cardiology problem. Fifteen health care records were selected from a four month period prior to November, 1973. They contained only narrative summary nurses' charting. Fifteen with problem-oriented nurses' notes were chosen from the January-February, 1974, period.

A nursing audit review schedule by Phaneuf (12) was used for gathering data on the nurses' charting format. Because the medical

resident physicians had been using the problem-oriented system on the medical units since 1972, the audit schedule (Appendix B) was modified to accommodate that system. Function I was changed from, "application and execution of physician's legal orders," to "application and execution of the problem-oriented record system." The subcomponent number 1, was changed from "medical diagnosis complete," to read, "problem list complete." Under Function III, subcomponent 13 was changed. It originally read, "evidence that initial nursing diagnosis was made." It was changed to read, "evidence that initial problems were identified."

It was necessary to ascertain whether or not the nursing audit tool was reliable for evaluating the problem-oriented health care recording system. An explanation of audit schedule components was submitted to fifteen students in a graduate nursing research class. They marked each subcomponent according to the area of of problem-oriented system they believed it would test. The areas were (a) data base and problem list, (b) subjective or objective observations, (c) assessment, and (d) plan or nursing order. The responses indicated the following: Functions I and VI evaluate the data base and problem list; Functions II, V, and VI evaluate observations; Functions III and VII evaluate the assessment that was made; and Functions IV and VII evaluate the plan. The results indicated that the audit tool would adequately test the areas of problem-oriented charting as well as narrative summary charting as described by Phaneuf in The Nursing Audit.

Thirty health care records were audited by a committee of three nurse auditors. (The auditors were the author, a medical

school hospital staff development administrator knowledgeable in charting methods, and a graduate nursing student who had previously used the Phaneuf audit tool in a hospital setting.) The first five days of the patient's admission to a medical ward using problem-oriented charting were reviewed. And for the narrative summary charts the first five days of the last hospital admission were reviewed. The records were reviewed in a counter balanced order to prevent response sets in the auditors. As a record was reviewed by each of the three auditors a consensus of opinion was reached. As each record was audited the data were entered on the nursing audit chart review schedule. The review schedule was divided into the seven functions of professional nursing. Subcomponents were listed under each of the seven major functions. The functions were as follows: application and execution of the problem-oriented record system, observation of the symptoms and reactions, supervision of the patient, supervision of those participating in care (except the physician), reporting and recording, application and execution of nursing procedures and techniques, and promotion of physical and emotional health by direction and teaching.

The answers on the evaluation tool were scored in accordance with Phaneuf's tool. (12) It should be noted that the functions' values are weighted. Some areas are weighted more heavily than others. The detailed subcomponents result in the development of subscores for each function. The scores of the individual functions were placed on a graphic summary table so that improvements in recording were readily recognizable if in fact they did exist. The total

point values that indicate excellence in each function are as follows:

Nursing Function	Total Point Value
I. Application and execution of physicians' legal orders.	42
II. Observation of signs and symptoms.	40
III. Supervision of the patient.	28
IV. Supervision of those participating in care.	20
V. Reporting and recording.	20
VI. Application and execution of nursing procedures and techniques.	32
VII. Promotion of physical and emotional health by direction and teaching.	18

The total of the subscores yield a final score for each case reviewed. The final scores are rated excellent (161-200), good (121-160), incomplete (81-120), poor (41-80), and unsafe (0-40).

CHAPTER III

RESULTS AND DISCUSSION

Using the audit tool, three nurse auditors reviewed thirty patient health care records; fifteen with narrative summary charting and fifteen with problem-oriented charting.

For the individual record, numeric totals were tabulated for each of the seven function divisions. These seven total scores were added for a final score. Every record had seven function totals and a final score.

The function scores of the fifteen narrative summary charts were totaled. An arithmetic mean score for each function was obtained. The seven function scores of the fifteen problem-oriented charts were also totaled. An arithmetic mean score for each function was obtained. The arithmetic mean scores of the seven functions for both methods of charting appear in Table 1.

Table 1. Function Scores: Arithmetic mean scores on seven functional areas of nursing for fifteen problem-oriented and fifteen narrative summary health care records.

CHARTING METHOD	FUNCTIONS						
	I	II	III	IV	V	VI	VII
PROBLEM ORIENTED	39.5	33.7	19.3	3.6	15.6	17.6	4.1
NARRATIVE SUMMARY	35.5	29.6	14.2	0.8	13.3	18.3	3

The arithmetic mean scores for the seven functions of professional nursing were then plotted on a graphic summary (Figure 1) for comparison of their profiles.

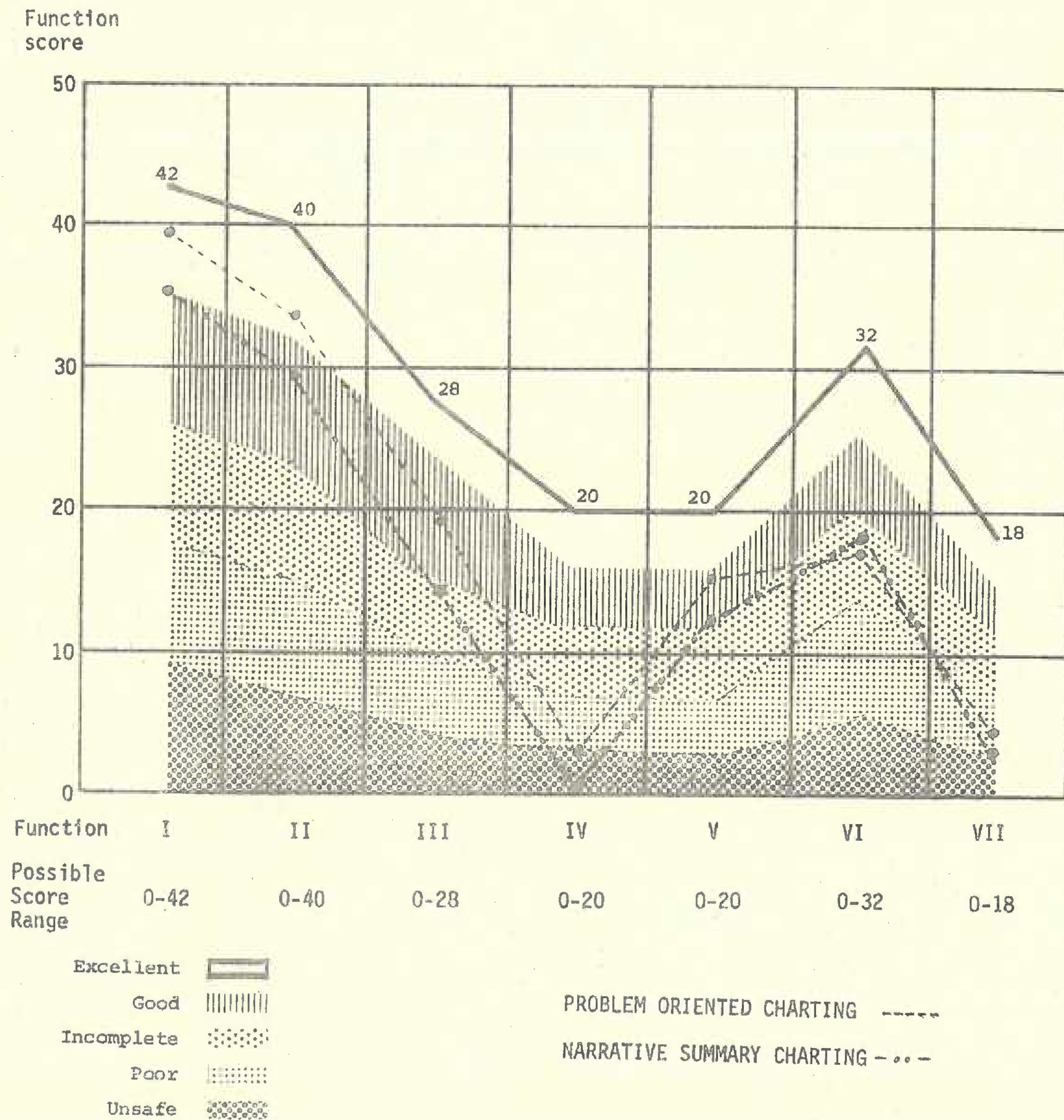

Figure 1. Quality Profiles Line Graph. Alignment of arithmetic mean scores for each of the seven nursing functions. A comparison of narrative summary charting and problem oriented charting.

The final scores of the thirty health care records were considered. The problem-oriented scores ranged from 114.45 to 176.13 with a mean of 140.69. The narrative summary scores ranged from 111.3 to 145.08 with a mean of 120.28. They were rated as excellent (161-200), good (121-160), incomplete (81-120), poor (41-80), and unsafe (0-40). The number of health care records in each category as well as the percentage represented are given in Table 2 below.

Table 2. Distribution of records into five categories, ranging from "excellent" to "unsafe", on the basis of final scores on Nursing Audit Tool.

CATEGORIES	Problem Oriented		Narrative Summary	
	Number	Percentage	Number	Percentage
Excellent	2	13%	0	
Good	12	80%	8	53%
Incomplete	1	7%	6	40%
Poor	0		1	7%
Unsafe	0		0	

The arithmetic mean scores of the seven functions (Table 1) are higher for problem-oriented charting in Functions I, II, III, IV, V, and VII. The narrative summary recording had more evidence of specific nursing procedures and techniques (Function VI), although the mean scores differed only by 0.7 point.

In Function I, application and execution of the problem-oriented record system, both charting methods are rated as 'excellent' (see Figure I). The second function which deals with recording

of the observation of symptoms and reactions, reveals that the problem-oriented record is in the 'excellent' category while narrative summary is in the 'good' range. Function III, supervision of the patient, shows 'incomplete' charting with narrative summary. But problem-oriented is in the 'good' range. In Function IV, supervision of those participating in care, both methods fell into the 'unsafe' category. Evidence of nurses' reporting and recording facts for patient care (Function V) were 'good' for both methods of charting. Both methods were 'incomplete' for recording the application and execution of nursing procedures and techniques (Function VI). Although it was in this category that the narrative summary mean score was above the problem-oriented mean score. Function VII, promotion of physical and emotional health by direction and teaching, was found to be 'poor' with both methods of charting.

Therefore, by functional categories the problem-oriented and narrative summary charting are similar in Functions I, IV, V, VI, and VII. In Functions II and III, problem-oriented charting is one category better than narrative summary.

According to the final score categories, two (13%) problem-oriented records rated 'excellent', as compared to no narrative summary record. Twelve problem-oriented and eight narrative summary charts were in the 'good' division. Only one problem-oriented record was 'incomplete', while six narrative summary records were 'incomplete'. There was one narrative summary record in the 'poor' category. None of the records were considered 'unsafe'.

Consequently, 93% of the final scores of the problem-oriented charts were in the 'good' and 'excellent' categories. Only fifty-three percent of the narrative summary final scores were in the 'good' section and none in the 'excellent'.

The data collected indicate that there is more evidence of observations made and nursing care rendered recorded in the problem-oriented charting. However, in a descriptive study such as this there are many variables. The patient health care records differed greatly in the scope of illness identified on the problem lists. Some of the cardiology problems were minor; some required intensive care. Differences in the patient's sex and age also existed. In the problem-oriented records there were ten female and five male patients. Their ages ranged from 51 to 91 years with a mean of 71 years. In the narrative summary records there were three female and twelve male patients. Their ages ranged from 41 to 84 years with a mean of 56 years. There were a variety of nursing personnel charting on the records. There were student nurses, aides, licensed practical nurses and registered nurses entering information on the health care records. And, the nurses, who charted, changed from shift to shift and day to day.

There may have also been a Hawthorne effect. The medical unit staff nurses received special instruction on the new charting method. This may have enhanced their knowledge of charting. They may have been stimulated to try harder to get their charting done. Because of the newness of the method there may have been a feeling of competition which encouraged improvement.

This would compare to Phaneuf's study. (12) In her study, the follow-up audit, after six months of effort to improve charting, shows an increase in the quality of charting (see Figure 2). Figure 2 also reveals that Function IV and VII were areas needing improvement. This indicated a general need for improvement of recording of instruction given to patients and family members, and of the use of appropriate referrals.

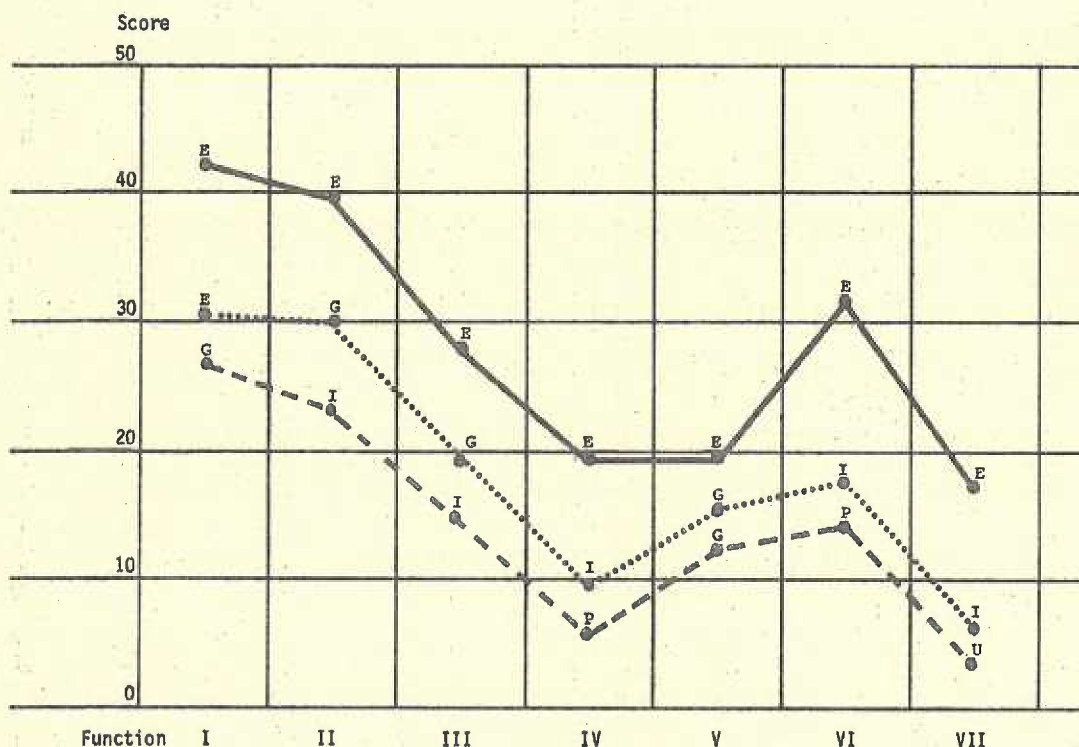

FIG. 2. Quality profiles: alignment of findings: acute general hospital. First audit, 50 cases; audit 6 months later, 50 cases; and comparison with profile of excellence. Excellence ———, First Audit – – – – –, Audit 6 months later……, E Excellent, G Good, I Incomplete, P Poor, U Unsafe. (12)

Problem-oriented charting was instructed only as a different method of recording. It would be of interest to see what improvements in recording might follow six months of concentration on

weak areas using this method.

A six month follow-up audit on the medical units utilizing problem-oriented charting would be recommended. This would give more discerning evidence of whether or not problem-oriented charting is a better method of recording than the narrative summary method.

CHAPTER IV

SUMMARY

There is a need for nurses to consistently record observations made and nursing care rendered. This study was undertaken to determine if problem-oriented charting would give more evidence of observations made and nursing care rendered than would narrative summary charting.

A nursing audit chart review schedule was used to audit thirty patient health care records with a cardiology problem on the problem list. Narrative summary charting was reviewed in the fifteen charts selected from the four month period prior to November 1, 1973. Problem-oriented charting was reviewed in the fifteen charts selected from January through February, 1974.

The data were scored according to subcomponents of seven functions of professional nursing. The seven function scores were added to obtain a final score. The function scores and final scores were tabulated for both charting methods. Arithmetic mean scores were determined and used for comparisons. The functional and final scores were also placed in categories of excellent, good, incomplete, poor, and unsafe.

The arithmetic means of scores assessing the several functions revealed that problem-oriented charting scores were higher in six of the seven functions. By functional categories both methods were the same in five functions; problem-oriented was better in two

categories. According to final scores ninety-three percent of problem-oriented charts were in the 'excellent' and 'good' divisions. The narrative summary charts had only fifty-three percent in the 'good' division and none in the 'excellent'.

There was more evidence of observations made and nursing care rendered when the problem-oriented charting format was used than when narrative summary charting was used.

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APPENDICES

Good Samaritan Hospital
and Medical Center
1015 N. W. 22nd. Avenue
Portland, Oregon 97210
April 9, 1974

Mrs. Joyce Johnson
Route 2, Box 463A
Molalla, Oregon 97038

Dear Mrs. Johnson:

Regarding your request of April 5, 1974, you have my permission to audit closed patient charts in our Medical Record Department if this meets with their approval.

Sincerely,

(Miss) Margie Hanley, R. N.
Director of Nursing Service

MH:vs

APPENDIX B

Nursing Audit Chart Review Schedule Modified From Phaneuf (12)

PART II. NURSING AUDIT CHART REVIEW SCHEDULE

All Entries To Be Completed By A Member Of the Nursing Audit Committee

(Please check in box of choice; DO NOT obscure number in box.)

Name of patient: ______________________________
(LAST) (FIRST)

	YES	NO	UNCERTAIN	TOTALS
I. APPLICATION AND EXECUTION OF THE PROBLEM-ORIENTED RECORD SYSTEM				
1. PROBLEM LIST COMPLETE	7	0	3	
2. Orders complete	7	0	3	
3. Orders current	7	0	3	
4. Orders promptly executed	7	0	3	
5. Evidence that nurse understood cause and effect	7	0	3	
6. Evidence that nurse took health history into account	7	0	3	
(42) TOTALS		0		
II. OBSERVATION OF SYMPTOMS AND REACTIONS				
7. Related to course of above disease(s) in general	7	0	3	
8. Related to course of above disease(s) in patient	7	0	3	
9. Related to complications due to therapy (each medication and each procedure)	7	0	3	
10. Vital signs	7	0	3	
11. Patient to his condition	7	0	3	
12. Patient to his course of disease(s)	5	0	2	
(40) TOTALS		0		
III. SUPERVISION OF THE PATIENT				
13. EVIDENCE THAT INITIAL PROBLEMS WERE IDENTIFIED	4	0	1	
14. Safety of patient	4	0	1	
15. Security of patient	4	0	1	
16. Adaptation (support of patient in reaction to condition and care)	4	0	1	
17. Continuing assessment of patient's condition and capacity	4	0	1	
18. Nursing plans changed in accordance with assessment	4	0	1	
19. Interaction with family and with others considered	4	0	1	
(28) TOTALS		0		
IV. SUPERVISION OF THOSE PARTICIPATING IN CARE (EXCEPT THE PHYSICIAN)				
20. Care taught to patient, family, or others, nursing personnel	5	0	2	
21. Physical, emotional, mental capacity to learn considered	5	0	2	
22. Continuity of supervision to those taught	5	0	2	
23. Support of those giving care	5	0	2	
(20) TOTALS		0		
V. REPORTING AND RECORDING				
24. Facts on which further care depended were recorded	4	0	1	
25. Essential facts reported to physician	4	0	1	
26. Reporting of facts included evaluation thereof	4	0	1	
27. Patient or family alerted as to what to report to physician	4	0	1	
28. Record permitted continuity of intramural and extramural care	4	0	1	
(20) TOTALS		0		

PART II. NURSING AUDIT CHART REVIEW SCHEDULE (cont.)

VI. APPLICATION AND EXECUTION OF NURSING PROCEDURES AND TECHNIQUES	YES	NO	UNCERTAIN	TOTALS	DOES NOT APPLY
29. Administration and/or supervision of medications	2	0	0.5		2
30. Personal care (bathing, oral hygiene, skin, nail care, shampoo)	2	0	0.5		2
31. Nutrition (including special diets)	2	0	0.5		2
32. Fluid balance plus electrolytes	2	0	0.5		2
33. Elimination	2	0	0.5		2
34. Rest and sleep	2	0	0.5		2
35. Physical activity	2	0	0.5		2
36. Irrigations (including enemas)	2	0	0.5		2
37. Dressings and bandages	2	0	0.5		2
38. Formal exercise program	2	0	0.5		2
39. Rehabilitation (other than formal exercise)	2	0	0.5		2
40. Prevention of complications and infections	2	0	0.5		2
41. Recreation, diversion	2	0	0.5		2
42. Clinical procedures - urinalysis, B/P	2	0	0.5		2
43. Special treatments (e.g., care of tracheotomy, use of oxygen, colostomy or catheter care, etc.)	2	0	0.5		2
44. Procedures and techniques taught to patient	2	0	0.5		2
(32) TOTALS		0			

VII. PROMOTION OF PHYSICAL AND EMOTIONAL HEALTH BY DIRECTION AND TEACHING	YES	NO	UNCERTAIN	TOTALS	DOES NOT APPLY
45. Plans for medical emergency evident	3	0	1		3
46. Emotional support to patient	3	0	1		3
47. Emotional support to family	3	0	1		3
48. Teaching promotion and maintenance of health	3	0	1		3
49. Evaluation of need for additional resources (e.g., spiritual, social service, homemaker service, physical or occupational therapy)	3	0	1		3
50. Action taken in regard to needs identified	3	0	1		3
(18) TOTALS		0			
TOTAL SCORE					
FINAL SCORE					

PART III. AUDIT RESULTS

All Entries To Be Completed By A Nursing Audit Committee Member

Record reflects service as:

EXCELLENT (161-200)	GOOD (121-160)	INCOMPLETE (81-120)	POOR (41-80)	UNSAFE (0-40)
☐ ( )	☐ ( )	☐ ( )	☐ ( )	☐ ( )

Record did not permit appraisal ☐ Why?

Remarks (including criticisms/questions pertinent to policy procedures, practices as shown in Parts I and II):

Signature of Nursing Audit Committee member who reviewed the record.

Date:

APPENDIX C

Explanation of Audit Schedule Components Adapted from Phaneuf (12)

EXPLANATION OF AUDIT SCHEDULE COMPONENTS

FUNCTIONS AND SUBCOMPONENTS

FUNCTION I: APPLICATION AND EXECUTION OF THE PROBLEM ORIENTED RECORD SYSTEM

I. Problem List Complete. The problem list is complete when all the patient's problems, past as well as present, social and psychiatric, as well as medical and/or nursing have been entered. The list should not include diagnostic guesses, but simply state the problem at a level of refinement consistent with the physican's and nurse's understanding, encompassing the gamut of precise diagnosis (medical and/or nursing) to the isolated unexplained finding.

Each problem entry is dated, numbered and titled. A problem is identified by asking:

(I) Is it a medical/nursing or a social problem?
(2) If medical/nursing it should be classifiable as
   a. a diagnosis (medical or nursing).
   b. a physiological finding (identified by physician or nurse).
   c. a symptom or a physical finding (observed by physician or nurse).
   d. an abnormal laboratory finding.
(3) If social, precisely defined.

2. Orders Complete. The doctor's/nurse's orders are clear explicit and conclusive when looked at in regard to the patient, the diagnosis and other clinical data.

An explicit, clear order includes date, time, frequency, indication of priorities and who is responsible. The delegation of responsibility reflects abilities and skills of those who will execute the order. An order is conclusive as one or a combination of the following:

(1) A medical/nursing diagnosis
(2) A medical/nursing therapy planned
(3) Patient and/or family teaching
(4) Follow-up of medical and/or nursing care
(5) Discharge planning

3. Orders Current. Orders are up to date according to pertinent institutional or agency policy and nursing judgment. The order is discontinued when the result is either achieved or becomes inappropriate.

4. Orders promptly executed. The chart shows reasonable and appropriate timing between the giving of the order and compliance with it.

5. Evidence that the nurse understood cause and effect. The chart

shows that the nurse knew and/or understood the basis for physiological, psychological and/or sociological results of any service she performed, including possible side effects, complications or implications.

6. Evidence that the nurse took the health history into account. Recordings reflect recognition that knowledge of pertinent points in the patient's past pattern of health and illness are essential to current nursing care. The data base is completed.
   The health history (data base) identifies data from which to make nursing assessments of strengths, weaknesses and life style which are taken into account when planning nursing intervention relative to the patient's problems.

FUNCTION II: OBSERVATION OF SYMPTOMS AND REACTIONS

7. Related to the course of the disease and the planned procedure in general. Evidence shows that the nurse's observations were made using the classic picture as her clinical frame of reference.
   By this is meant that the natural history of the disease from which the patient suffers should be known by the nurse and used as the clinical base for developing nursing care.

8. Related to the course of the above disease and the planned procedure in this patient. There is evidence that, in addition to the knowledge of the disease (item 7), there are observations of the patient's individual response to the disease and its treatments or to the procedure.
   Observations are made of the patient's: (1) response to the disease/treatment/procedure which may be influenced by his heredity, general health, and life situation; (2) physical status; (3) mental states, such as, his behavior pattern, morale fluctuations, emotional disturbance; (4) spiritual status by making arrangements for clergy visits, food habits; (5) financial resources by informing employer of patient's illness and its duration; contacting social service; (6) psychosocial status by identifying what the patient knows about his illness, what hospitalization means to him, and patient-family relations.

9. Related complications due to therapy. Nursing observations relate to expected therapy and possible or unexpected untoward side effects. Such a side effect might be pain and recording observations relative to pain would include duration, intensity, location, quality, effects of movement or position, facial expression, posture, or use of pain medications.

10. Vital signs. When indicated by the patient's situation recording includes:
    (A) temperature
    (B) pulse -- rate, quality, rhythm.
    (C) respirations -- rate, quality, and rhythm.

(D) blood pressure
(E) skin -- tone, temperature, color.
(F) patient's affect -- feeling tone.

11. Patient to his condition. There is evidence that attention was given to the patient's attitude toward his clinical condition and life situation as it influences and is influenced by, the clinical condition.
    Attention includes careful consideration of behavior and attitudes obtained as verbal or nonverbal responses by the patient.

12. Patient to his course of disease and to the planned procedure. Evidence indicates that attention was given to the patient's understanding, acceptance, rejection, or ambivalance about his disease or the planned procedure.

FUNCTION III: SUPERVISION OF THE PATIENT

13. Evidence that initial problems were identified and listed and the data base (health history) and were later incorporated with the the doctor's problem list. The chart shows that the patient's problems were determined and listed beginning with admission and continuing throughout hospitalization. This data base information becomes the basis for nursing care directed toward solution of the problems. The data base should be completed as soon as possible after the patient's arrival, but definitely within the "shift".
    Determination and listing of the patient's problems encompasses the steps of the nursing process by taking a nursing health history, completing a clinical inspection, and making an assessment up to the point of priority setting and formulation of a plan of care.

14. Safety of the patient. Precautions were taken, and recorded, to prevent physical injury. Such precautions include assistance with activities involving neuromuscular function, availability of call light, explanation or warning regarding sensory or body defect, documentation of patient's degree of mental responsibility or level of consciousness.

15. Security of the patient. There is evidence of productive interpersonal relationships, as well as attention to the physical setting in which the human interaction occurs (room arrangement, heat, light, ventilation) which helps to maintain a therapeutic environment for the patient.

16. Adaptation (support of patient in reactions to condition, procedure, care). There is record of attempts to help the patient adjust to his changing condition, the procedure, his care and to his anticipated future. For example helping reduce the patient's anxiety, fear and doubt about the disease condition or a procedure; explaining the condition or procedure to gain his confidence in the nursing care.

17. Continuing assessment of patient's condition and capacity. There is evidence of an ongoing appraisal of the current status of the patient and the effects of the care. An ongoing appraisal which is based upon the steps of the nursing process includes the nursing health history data base, clinical inspection by subjective and objective observations, and data from other sources. The assessment or interpretation of this data provides the basis for modification of the plan of care.

18. The nursing plan of care changed in accordance with assessment. The chart shows that the plan of care or nursing orders were adapted as the patient's problems were altered by changes in his condition or capacity.

19. Interaction with the family and with other people considered. There is evidence of concern for the patient's ability to interact with his family and members of the health team.

    Interactions are observed with respect to the interests and concerns reflected by the patient and family and used to advance mutually constructive relationships.

FUNCTION IV: SUPERVISION OF THOSE PARTICIPATING IN CARE EXCEPT THE PHYSICIAN

20. Care taught to patient, family or others participating in his care. There is evidence of what care was taught, to whom, by whom, and how guidance, support and assessment of learning were accomplished.

    Care taught encompasses all activities resumed or assumed by the patient and all the tasks performed by others involved in his care.

21. Physical, mental and emotional capacity to learn considered. The recorded data identifies the ability and readiness of the learner including appropriateness of what is to be taught to the learner, or any language barrier present.

22. Continuity of supervision to those taught. There is documentation that initial and subsequent teaching was assessed and appropriate modifications made in the plan of care.

23. Support of those giving care. The chart shows that emotional and/or physical help was given to those taught. Help would entail an appropriate nursing plan or care based on or in accordance with the assessment.

FUNCTION V: REPORTING AND RECORDING

24. Facts upon which further care depended were recorded. The information recorded facilitated continuing physician and nurse management of clinical care.

    Minimum information includes observations of symptoms and reactions; evidence of the execution of orders; and data developed

as part of the supervision of the patient.

25. Essential facts reported to the physician. There is written documented evidence that pertinent data was communicated to the physician either in writing or verbally. Pertinent data includes that which is indispensible to the physician and that which is clinically significant as a discrete fact to the physician in his management of the patient's problems.

26. Reporting of facts included evaluation thereof. There is definite statement of the reason why the nurse considered the facts indispensible and clinically significant enough to chart.

27. Patient and family alerted to what facts to report to the physician. The chart reflects that the patient and family were instructed to report directly to the physician such facts as signs, symptoms, or situations. This fosters physician-patient/family interactions concerning questions the nurse cannot or should not answer. The nurse will still assume the responsibility of reporting directly to the physician.

28. The chart permitted continuity of care. The information charted about a problem flows in a logical sequence from nurse to nurse such that continuity of care can be documented from charted information.

FUNCTION VI: APPLICATION AND EXECUTION OF NURSING PROCEDURES AND TECHNIQUES

29. Administration of medications/supervision of their use. The chart reflects nurse/patient and or family awareness of medication's action and principle side effects.

    For every medication (regardless of whomever administers it), whenever untoward side effects are observed, including reactions of intolerance and idiosyncrasy and or incompatabilities, these are recorded.

30. Personal care (bathing, oral hygiene, skin, nail and hair care). Observations are recorded which indicated appropriate attention was given to personal care whether performed by the patient, family or another person.

    Appropriate attention encompasses observation of, assessment of and planning for cleanliness and may include grooming conducive to feelings of well-being, personal worth and dignity, type of bath, supervision necessary or special skin lubrication.

31. Nutrition including special diets. There is documented evidence as to whether or not and to what extent, the diet and the main reasons for it appear to be understood and accepted by the patient.

    There is an appraisal of the patient's usual eating habits in terms of nutrients as well as whether the food is prepared in a special way.

32. Fluid and electrolyte balance. There is evidence of consideration of possible disturbances in body fluid and electrolyte balance as indicated by the patient's age, condition and course of illness.
    Possible disturbances may include fluid intake, urinary output, changes in respiratory rate and depth, changes in skin turgor, dryness of skin and mucous membranes, changes in behavior, such as increasing apathy or restlessness, thirst, ascites, edema and vomiting.

33. Elimination. Evidence shows that bowel function was considered and appropriate action taken when bowels not functioning normally. The data base reflects what is normal for the patient in health and or illness.

34. Rest and sleep. The data base shows that usual patterns of sleep and rest were assessed. Attempts were made to follow the patient's natural rhythms in planning care. If a usual pattern was deficient, a regimen was implemented to appropriately alter the pattern.
    Documentation of sleep pattern may include: length of naps, facial expression, characteristics of sleep, environmental heat, light, ventilation or noise.

35. Physical activity. There is documentation as to the relationship between actual physical activity and what is clinically permissible. There may also be evidence that the patient was helped to understand and accept reasons that underlie restrictions or increases in his activity.

36. Irrigations of wounds, canals, cavities. Documentation about irrigations should include with what ease done, results, patient tolerance, discription or drainage and/or excreta.

37. Dressings and bandages. Evidence that nurse initiated as need indicated as well as identification of any topical applications, the kind of dressing used, the appearance of the wound site and adjacent tissues, the wound drainage or lack of it (color, consistency, odor, amount, extent, source, cause of drainage) and the identification of any removed sutures, skin clips or drains.

38. Formal exercise program. A treatment plan, initiated by a nurse should be documented including the patient's understanding of and cooperation with the program.

39. Rehabilitation. Evidence of teaching or encouragement toward independent living, active and passive R.O.M. exercises, use of aids in activities of daily living. If nursing rehabilitation is not required, there is evidence that nursing care planned and rendered is restorative in nature.

40. Prevention of complication -- including infections. Early de-

tection of complications that might reasonably be expected or prevented is part of an ongoing nursing assessment and subsequent planning.

41. Recreation and diversion. The chart indicated an assessment was made of the patient's need for activities which interest and amuse him and which divert his attention from his disease and illness. Recreational activities may indicate the extent of diversion and relaxation of the patient from his daily occupation.

42. Clinical procedures. There is documented evidence of the results of any procedure carried out by a nurse. The results should include observations, assessment and plans.

43. Special treatments (including tracheostomy management, use of oxygen, colostomy care, gastric feedings, care of decubiti). Evidence that treatments were done, results documented and assessed, observations made pertinent to the patient's physical and emotional reactions.

    The preparation of the patient for the special treatment (teaching) is a part of documented performance. Patient's perferences as to the way in which the procedure is to be performed should be recognized and adhered to. When unsafe to do so the record should indicate explanations given to enlist his cooperation.

44. Procedures and techniques taught to the patient. Evidence that any procedure or technique the patient can learn to carry out to his advantage is in fact taught, based upon an assessment of his capabilities.

FUNCTION VII: PROMOTION OF PHYSICAL AND EMOTIONAL HEALTH BY DIRECTION AND TEACHING

45. Plans for medical emergency. Evidence that by specific teaching, patient, family, and/or other nursing personnel knew what to do in worrisome or dangerous situations and in situations which arouse anxiety or fear in those responsible for his care.

    Prevention of and planning for an emergency is based on the nurse's knowledge and assessment of what the potential emergencies are and what the patient and his family perceive as constituting an emergency and what is perceived as a clinical emergency.

46. Emotional support for the patient. Emotional support requires a baseline assessment and documentation of the patient's emotional needs, his characteristic behaviors and his psychosocial and cultural matrix. This information should be initially documented at the time of the patient's admission on the nursing data base. Subsequent charting should provide evidence of helping the patient to understand and accept his feelings about himself, his condition, and his care by helping him to develope his coping abilities and other potentials.

47. Emotional support for the family. The chart documents assessments about the family's reaction toward the patient and his condition as well as a plan of care to help the family accept the patient's condition and their own feelings about it. Providing emotional support for the family requires the same type of data base information, assessment and subsequent planning as that required in emotional support of the patient.

48. Teaching preventive health care. The chart reflects both promotion and protection of the health of the patient and his family and of teaching about secondary prevention. This may include teaching about signs and symptoms which may indicate new disorders or complications due to established disease.
    The teaching plan formulated must be based on an assessment of the goals and the motivation of the patient and/or his family.

49. Evaluation of the need for additional resources, including spiritual guidance, social services, occupational therapy, or continuity of nursing care under another aegis; homemaker service.
    There is evidence that when indicated, possible needs for consultation or direct services were assessed.

50. Action taken in regard to needs identified. Evidence that nursing action was taken (with physician's knowledge) for needs identified as relating to the promotion of health, by direction and teaching of the patient's physical and emotional health.

APPENDIX D

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AN ABSTRACT OF THE FIELD STUDY OF

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Date of receiving this degree JUNE 7, 1974

Title: EVALUATION OF PROBLEM-ORIENTED CHARTING

Approved ______________

There is a need for nurses to consistently record observations made and nursing care rendered. This study was undertaken to determine if problem-oriented charting would give more evidence of observations made and nursing care rendered than narrative summary charting.

A nursing audit chart review schedule was used to audit thirty patient health care records with a cardiology problem on the problem list. Narrative summary charting was reviewed in the fifteen charts selected from the four month period prior to November 1, 1973. Problem-oriented charting was reviewed in the fifteen charts selected from January through February, 1974.

The data were scored according to subcomponents of seven functions of professional nursing. The functions are as follows: application and execution of the problem-oriented record system, observation of the symptoms and reactions, supervision of the patient, supervision of those participating in care (except the

physician), reporting and recording, application and execution of nursing procedures and techniques, and promotion of physical and emotional health by direction and teaching. The seven function scores were added to obtain a final score. The functional and final scores were also placed in categories of excellent, good, incomplete, poor, and unsafe.

The data revealed that problem-oriented charting scores were higher in six of the seven functions. According to final scores ninety-three percent of problem-oriented charts were in the 'excellent' and 'good' divisions. The narrative summary charts had only fifty-three percent in the 'good' division and none in the 'excellent'.

There was more evidence of observations made and nursing care rendered when the problem-oriented charting format was used than when narrative summary charting was used.