Rhode Island's Visiting Nurse Service Streamlines Its Patients' Records

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BULGING record files concerning patients have long been a headache to the Visiting Nurse Service (VNS) of Pawtucket, Central Falls, Lincoln, and Cumberland, R.I. Valuable time has been used in reviewing the multitude of forms before visiting a patient and in filling them out after a visit. And the records were not always a good management tool. Too often they were verbose, duplicative, incomplete, and even irrelevant.

In March 1971 the VNS shifted over to a new system, and today the agency files are reduced and much more useful. Six basic forms contain almost all the information needed concerning a patient, and the information is concise, comprehensive, and problem oriented.

In September 1969 the VNS had asked the management engineering department of the Pawtucket Memorial Hospital to undertake a study of VNS operations. The department staff consented. Costs of the study were funded by a grant to VNS from the Rhode Island Department of Health. Initially, innovative ways to counter the effects of a critical shortage of nurses were needed. As the project developed, a major concern centered on the possibilities of redesigning the records.

David Perlini, management engineer of the hospital, completed a study in June 1971. He had noted the considerable concern of the VNS about the quality of its records and the time staff nurses needed to complete them.

In addition to setting up a new records system, Perlini analyzed costs, staffing patterns, processing procedures, clerical systems, space requirements, handling of statistical information, and related issues.

Systems Review and Design

Examination of the old VNS records system had confirmed that it was ineffective. Too many forms only contributed to confusion and many differences in recording the information. There was considerable unnecessary repetition and no clear chronological recording of visits, so that summaries often had to be rewritten on the outside of the folder. There were ambiguous categories of information having little health or social value, recorded in a haphazard, nonstandardized manner. Additional forms had to be inserted in the record to compensate for data not provided

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for on existing forms. No information on the nursing care plan was provided to insure continuity and adequate supervision of care.

VNS was not anxious personally to undertake the task of designing and testing a whole new record system. The agency reviewed systems used in other jurisdictions in the hope of finding a set that could be readily adapted to its needs. Unfortunately it found most other systems suffering, to varying extents, from identical problems. On the other hand, it gained two new convictions from the review.

1. That the nursing care plan should be an integral part of the records on nursing care visits and not a separate form requiring cross-references or summaries.

2. That the use of codes, although advocated by the National League of Nursing (*1*), might better be avoided.

Training people to interpret differences in levels of care or progress by code numbers is extremely difficult owing to subtle differences in the code definitions. Not only does the information recorded assume an objectivity and exactness it really does not have, but reviewing information reported in codes also is difficult.

Cross-referencing to code definitions is unavoidable, and the continuity of the narrative is thus lost. Unless the codes have obvious large variances in their definitions, they are useless as a tool in review. And rather than a brief remark, the value tends to be canceled by the time spent by the nurse in trying to decide what general category to use.

In designing a new set of record forms to meet the needs experienced in practice, the goals of the VNS were to—

Reduce the number of forms
Reduce repetition to a minimum
Eliminate ambiguity
Eliminate irrelevant information
Design a record to facilitate completion by typewriter
Develop a nursing plan component as an integral part of the record
Design a record that would anticipate and allow the entry of as much pertinent information as possible.

Three basic forms resulted: the family identification or ID record, the service record, and the record of visits, which we will discuss in more detail. These three forms, with the standard forms for interagency referral, renewal of orders, and patient identification, are the six basic forms that currently make up our record file on patients.

The interagency referral and renewal of order forms are used by all health and social agencies in Rhode Island and are provided by the Rhode Island Department of Health. The patient identification form is used by all Visiting Nurse Services for computer work.

The newly designed forms were given 6 weeks of trial and then were revised to eliminate any problems encountered in using them. A State health department grant helped pay for printing 46,000 copies of each of three new forms, and they have been used since March 1971. The new forms also are being used by the Providence District Nursing Association and the VNS agencies in the Pawtuxet Valley and in Newport, East Shore, and Kent County.

Family Identification Record

The family identification record includes space for information on family names (last), district, tract, family identification, race, date of first contact, family income, address (number and street, city, State, zip code, telephone number, code, number of rooms, number of residents), directions and related precautions, family members, birthdate, sex, relationship, and pertinent notes. The reverse side of the record form contains the family health history and social notes.

"Tract" refers to the census tract in which the family resides. Since the entire State of Rhode Island has been census tracked, this information is included on most health records and encounter forms in the State. It provides a useful definition for subdivisions within the district and, because it is keyed to decennial census data, it provides a useful basis for analyzing the VNS caseload and planning for future services.

We have sought to avoid the use of codes wherever possible, but there are places where a code can be helpful. Code, on this form, refers to housing.

Directions and related precautions include travel directions to the family home and related information for the visiting nurse; for example, "beware of the dog."

Family history includes notes concerning chronic conditions, serious bouts of illness, accidents and injuries, allergies, tuberculosis, alcoholism, drug addiction, diabetes, cancer, cardiac conditions, mental illness or retardation, and neurological conditions.

Social data include the following:

Environmental factors affecting health status—

- Physical condition of home
- Toilet facilities
- Running, hot water
- Heating
- Sleeping arrangements
- Food storage and cooking facilities
- Cleanliness, safety

Social factors affecting health status—

- Adult relationships
- Care of children, such as cleanliness, nutrition, clothing, parental attitudes, sibling relationships, school attendance, progress

Economic factors affecting health status—

- Problems in budgetary management
- Inabilities to acquire health services

Specific health care needs of the patient being visited are not included—although those of related family members may be—because this function is part of the nursing care plan appearing on the record of visits.

Service Record

The front side of the service record form includes information on the following:

Child health

- Name and address
- Physician, admission, discharge, birth
- Prenatal care physician, month care is initiated
- Birthweight: describe abnormal delivery
- Condition of child at birth
- Significant facts
- Disease history dates (current incidence)
- Communicable (specify)
- Allergies
- Upper respiratory infection
- Operations
- Accidents
- Emotional
- Other

Immunization and tests

- 1st, 2d, 3d, and booster
- Poliomyelitis
- Diphtheria, tetanus, pertussis
- Diptheria tetanus
- Measles
- Rubella
- Smallpox
- Tine
- Glucose
- Hemoglobin
- Lead
- Hearing Right Left Date
- Vision Right Left Date
- Permission for immunizations and tests, by

Maternity

- Physician, admission, discharge
- Name: mother, child, address
- District, tract, gravida, para, expected delivery date
- Plans for delivery
- Significant facts in health history
- Infant liveborn, stillborn, abortion, months gestation, sex, birthweight
- Delivery by, date, place, type
- Complications
- Condition at birth
- Post partum examination date, by
- Family planning

The visiting nurse is not primarily concerned with writing a social profile or report on the patients she visits. She does, however, observe and note conditions that could affect the health of the family or interfere with the effective provision of care to her patient. She is particularly instructed not to report information that is not directly pertinent and significant to the case at hand. For example, if the home is not neat but this fact has little or no effect on patient care, it should not be included in the social notes.

The reverse side of the service record form includes information on—

Morbidity

- Physician, admission, discharge
- Physician, readmission, discharge
- First visit, how long ill, date of operation
- History of illness and symptoms
- Hospital admission, hospital discharge, up and about
- Status at discharge: recovered or improved, dead, moved, other
- Medicare No., hospital insurance, medical insurance, State aid card

General health

- Address
- Telephone, physician, admission, discharge

Readmission, discharge, readmission, discharge
Date, physician or clinic, address and telephone number, institutional care, admitted, discharged
Blood tests, cardiograms, cultures, smears, urinalysis, X-ray examinations, and so on

One service record is used for each patient. If the record is for a newborn child, information on the mother is included in the maternity section; thus information for both mother and child is available for easy scanning and comparison.

In the morbidity section, space is provided for readmission date, to cover instances in which the same service record may be used because the patient was readmitted for the same condition.

The space provided under history of illness and symptoms can also be used to record first orders if the record is started before a referred person arrives, confirming the telephone order. The bottom line of this section is for recording the patient's medicare number and the effective dates of his hospital and medical insurance. If the VNS clerk requires a signature on a State aid card, this fact is indicated by a checkmark in the box at the end of the line, and the nurse will then know that a card must be obtained when the patient is visited.

The general health section is used to record appropriate information concerning blood tests, cardiograms, cultures, urinalysis, and so on. Space is provided to record the patient's visits to a clinic or private physician's office.

This section (other than infant, preschool, or morbidity) also can be used in admitting any patient into a health advisory category, such as mental hygiene or tuberculosis.

Record of Visits

The purpose of the record of visits is threefold: (*a*) the chronological reporting of services provided a patient in his home or a clinic, (*b*) the reporting of unusual situations and reactions, pointing out specific needs and problems relevant to his condition, and (*c*) the development and description of a planned approach to meeting the needs and problems of the patient, relevant not only to the specific condition being treated but to his overall health status as well.

Each patient has a separate record of visits. If a newborn is the admitted patient, information about the mother also may be entered on the form. The first 12 columns provide basic data about the patient and selected aspects of providing care.

The remainder of the form is used to summarize the course and purpose of care in a fashion oriented to the problem. It is, in a sense, the rationale for care. It provides a clear, concise description of what is being done and why, for the visiting nurse, nurse supervisor, or physician who reviews the record. Not least among its merits is that it helps the visiting nurse keep the course of treatment in perspective.

This form includes the name of the patient, date of service, care, temperature-pulse-respiration data, dates of interim visits to physician or clinic, child health (home or clinic care, age, weight, height, maternity data); nurse and fee; care given (observations on pertinent physical, social, and mental factors); and plan (instructions and future care).

The nurse records information in this section in the following order: medications, care given, and conditions, whether physical, psychological, social, or economic; approach, progress, and plan for further treatment. Notations are kept brief, and material already recorded on the service record is not repeated. The nurse does not actually record information under the headings given; they represent only a mental order of the comments she will write. The various points may be discussed in separate paragraphs if this format seems warranted.

Medications are always recorded first, in red, which makes them easy to find and difficult to miss. Included are medications the patient has been taking and medications or treatments that are administered during the nurse's visit. In the second and subsequent visits, medications are recorded only when they are changed or when a treatment is administered.

After the medications have been recorded, the nurse notes the care given, problems encountered, steps taken to alleviate the problem or meet a need, and progress in the approach to total care of the patient. At the end of the notes the nurse outlines the plan for future care.

Reaction to New System

After the revised forms were used for 6 months, questionnaires were sent to the five participating agencies to ascertain their reactions. The overall reaction was favorable. All agency staff workers said they found the three basic forms easier to use and fill out than the multiple records used before. They had some difficulty with the mechanical handling of the booklike form, as it had been

developed for VNS records that were to be typed from a dictaphone. This criticism is legitimate and one that can be corrected in later printings if the difficulty continues after a longer period of use.

Four agencies found review and supervision of the records to be good. The same agencies also followed the original guidelines for incorporating the nursing care plan as an integral part of the record. Two agencies were having difficulty incorporating the plan as a recorded day-to-day development and were concerned with statements of goals—long range, short term, immediate. All agencies, however, were enthusiastic about including the nursing care plan as part of the record rather then keeping it on a separate sheet.

All the agencies have found that 6 months is too short a period to assimilate or to evaluate a new system. The record formats have been accepted, but most important is the adoption of the problem-solving method, with its emphasis on professionalism, conciseness, and organization. Another questionnaire will be sent to the agencies after 1 year.

Lists (see box) provided during orientation include possible problems and are intended to serve as a memory jogger to new nurses.

Value of New System

The record of visits form has presented the greatest challenge but also has produced the greatest improvement in our agency's delivery of services to the consumer. We have found it to be an excellent tool for review by the supervisor and the staff nurse. It is especially useful to orient a new staff nurse to the ongoing situation in a home.

We are making more intelligent use of the standard interagency referral form, which serves as the start of care in nursing. This form gives the original physician's orders and the current status of the patient in medical, social, and physical care.

The standing renewal of order form, which must be signed by the physician every 2 months or more often, has become more useful as a summary sheet incorporated into the record. It also serves as a review of the patient's present status, including all medications currently being used in the home. This report has proved to be valuable when sent to the attending physician for his signature. It brings to his attention medications prescribed by other physicians, outdated medications, and in some instances contraindicated medications. VNS has received favorable comments from the physicians regarding these reports. They are beginning to view the form as an important report of their patient's condition rather than a necessary nuisance demanded by Medicare. The form also is used by the physical therapist and for any other report of patient care written chronologically, such as telephone calls, conferences, and so forth.

Our records have improved not only as an informational tool for the nurse, not only in the incorporation of a meaningful, current, vital nursing care plan in the record, but also in facilitating supervision. The nurse supervisor can tell at once the individual requirements of the visit, its relation to the goals set by the initial interagency form, and its success in reaching the goals on the renewal of orders summary sheet. Also, nursing notes can be typed directly from the record and a copy sent to the hospital-coordinated home care program, which requires a report concerning its patients every week. This procedure has saved a great deal of nursing and clerical time because duplication of the reporting information is avoided.

Administratively, the new record system has

Memory Reminder to New Nurses

Physical measures needed to protect the health of all concerned—
- Personal care
- Nutrition
- Treatments, including problem of medication, dressings, and so forth
- Environmental hazards
- Prosthetics
- Equipment

Psychological (emotional or behavioral) needs, which may be indicated by the patient's or family's response and attitude toward—
- Response to illness, diagnosis, care, treatment
- Ability to adjust to changes of above
- Family relationships relevant to care of condition
- Fear, loneliness, anxiety and worry, hostility, apprehension

Social and other professional sources, which may be of help, such as—
- Occupational therapy
- Vocational counseling
- Psychological services
- Legal counseling
- Institutional placement

Economic assistance, which may be indicated when financial problems interfere with the health of those concerned. If the acquisition of health care is deficient due to financial problems, consider where they might obtain assistance.

proved to be excellent for meeting the requirements of the fiscal intermediary, as well as for internal audits for measuring the use of skilled nursing care. All the facts are available.

I would hesitate to say that the records plan represents utopia. It requires greater discipline, but, once the nurse understands it, recording becomes automatic. More thorough orientation of the new staff nurse is needed because of it, but once done the system is a more valuable supervisory tool. It does not allow room for statements of generalized goals such as "raising a patient to the optimum level of health," but pinpoints specific needs, which in turn determine the actual plan of care; for example, good foot care in the partially blind diabetic.

The staff nurses have accepted the new method. The simple format and the fewer records have relieved a great deal of their frustration. They and the patients have benefited by having a well-designed record to use for planning patient care.

REFERENCE

(*1*) National League for Nursing: Records system guide for a community health service. Publication No. 21–1398. New York, 1970.

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The Visiting Nurse Service of Pawtucket, R.I., contracted with the management engineering department of Pawtucket Memorial Hospital to undertake a study of VNS operations, with a major concern centered on redesigning the patients' records.

Major goals were: reduction in the number of forms, development of a nursing care plan component as an integral part of the record, and elimination of repetitious, ambiguous, and irrelevant information.

Three basic forms resulted: the family identification record, the service record, and the record of visits. The family identification record provides for the collection of information concerning all persons within a family or household unit. The service record provides for a chronological reporting of services given to a patient in the home or clinic. This one record covers morbidity, general health, child health, and maternity services. The record of visits provides a planned approach to meet the needs and problems of the patient relevant to his health status.

The redesigned records are used by five other Visiting Nurse Services in the State. The problem-solving approach provides for concise, chronological reporting of services given patients at home or in the clinic. The incorporated nursing care plan has been found useful for review by the supervisor and the staff nurse.

Modern management engineering science was used in developing a compact nursing record. This innovative approach resulted in a system that concentrates mainly on patient care and management of the patient's problems.