Simplifying Local Service Records

By ALPHA K. KENNY

PROBLEMS associated with records are causing many health departments serious concern. The situation is becoming more acute with the continuing shortage of qualified personnel.

Like many other health departments in North Carolina and other States, the Orange-Person-Chatham-Lee District Health Department, with headquarters at Chapel Hill, N. C., had by 1950 outgrown its record system, which was installed in 1936. In those 14 years, public health had made significant progress by way of expansion into additional areas of health needs and in the quality of health services. Local health programs had changed in direction and in scope to meet changing demands. Special records had been added for some of the new programs, and procedures had been improvised for others in an attempt to record data required for case management and reporting.

A health department record system, if it is to be effective, should reflect accurately and adequately the problems in and services to the community. It should also facilitate and simplify the work of the health department. The opposite seemed to be true at Chapel Hill, where progress was impeded at times by lack of accessible information, where recording delayed rather than facilitated the work, and where duplication of entries and numerous separate files of different records complicated operations.

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Recognition of Need

In 1950, a nurse doing graduate work at the University of North Carolina School of Public Health undertook as part of her study program an investigation of the clinical and nursing service records then in use in the district headquarters at Chapel Hill. Members of the health department staff collected copies of forms and explained to the student when, where, how, and by whom each one was used. That procedure revealed the inadequacies of the record system and emphasized the urgent need to adjust the lag between the system and the current stage of program development.

However, this experience was not the beginning of the realization that these records were outmoded. For some time, the district health department had served as a field-experience center for the School of Public Health and the North Carolina State Board of Health. The district health officer and the nursing supervisor had been concerned about the unsuitability of the records for both teaching purposes and program operation.

A department of field training had been established in 1948 at the School of Public Health for the purpose of stimulating and assisting the development and use of inservice

training. Early in 1950, an educational director with wide experience in public health records and statistics was employed to develop the records phase of the department's program.

Launching the Project

The development of a new record system requires time for study, opportunity for discussion of needs, technical guidance, and readiness on the part of the staff to accept change and to endure the burden of extra work during the transition from one system to another.

With the several situations mentioned above as stimuli for action, serious consideration of a plan to meet the needs of both the health department and the department of field training got under way in July 1950 at a regular staff conference of the district office. The educational director from the School of Public Health participated in the conference. Discussion centered around principles of records and methods simplification, trends in narrative recording, and the need for teamwork in introducing a new record system. Thereupon, the district health officer requested from the North Carolina State Board of Health approval to proceed with the project. Two records consultants on the State staff were assigned to participate in the project.

The full medical, nursing, and clerical staffs of the district office, the State records consultants, and the educational director from the School of Public Health were present at the next conference, also held in July 1950. The sanitation staff did not participate in the project. The conferees agreed that future meetings would be scheduled as frequently as necessary and that the work should proceed as rapidly as possible so that it would not interfere with current program activities. The group set up the following objectives and specific needs for the project.

Primary Objectives: A simplified recordkeeping system, adequate for case management, reporting, and program planning.

A system suited to the current level of program development.

A unified picture of all services provided for an individual and a family unit.

Secondary Objectives: Preservation of the records in files readily accessible during the period of their usefulness.

Provision of basic statistical data for evaluation and administration.

Design of records which would serve as effective tools for teaching content and management of records.

Specific Needs: Eliminate, insofar as possible, the duplication of entries.

Reduce the number of forms by combining as many as possible.

Standardize the size of forms.

Encourage meaningful narrative recording.

Facilitate keeping the data up to date.

Design a family folder to hold all correspondence and records pertaining to members of a family.

Facilitate the filing of records.

Economize on filing space.

Establish central control of service records.

Economize on time spent on recordkeeping.

The enthusiasm revealed by the group as they grasped the objectives and the ease with which close teamwork developed was interesting. The specialized knowledges and skills of the individual members were so blended that it was difficult later to determine with which one specific ideas originated. Each contributed and each learned from the others. As many as three conferences were held in a week, and some members of the team worked full time—even overtime—on the project between conferences.

Early in the undertaking it was decided to abandon the idea of revising the old forms and instead to develop new forms on the basis of current programs of service, considering both the reporting requirements of the State and and Federal agencies and the more detailed administrative needs of the local department. The ever-present reminder of the difficulties experienced with the old system and the realization that public health is not static resulted in ample allowance for future expansion.

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Rough sketches of proposed forms were drawn and presented by various participants from time to time. Some were accepted in part or in whole; others were rejected. The rejected sketches were redesigned and presented again. By this process there emerged for experimental use a master card, a family folder (containing a family data sheet and a family service narrative form), and an individual observation record.

These forms comprise the basic simplified service records. They provide for a summary of all clinical and nursing services to an individual, a record of pertinent information on the family as a unit, a narrative record of each service to an individual member or to the family as a group, and a record of all clinical services to an individual.

Master Card

The master card, an 8- by 5-inch form designed for use on both sides, summarizes all services provided for an individual. Each person registered with the department has such a card. Sometimes it is the only record for the individual. It combines information formerly recorded on six separate forms, namely, birth summary, immunizations, index, laboratory diagnostic services, X-ray reports, and death summary. It also provides for recording single visits or limited services to avoid opening and closing another record.

The first section of the card has space for identifying information, including name, race, sex, date of birth, registration number, name of father or husband, name of mother or wife, and mailing address.

The second section replaces and is identical to the former immunization card, with the addition of write-in spaces for immunizations which may be introduced in the future. It includes lines for recording by date immunizations for whooping cough, diphtheria, tetanus, smallpox, and typhoid.

The third section, a summary of basic records, compares with the old index card. It has columns for the date of first admission to a service, the type of service, the name of the basic form on which the service is recorded in detail (family service narrative, individual observation record, tuberculosis program register, or orthopedic clinic record), the file in which the form may be found, and the date the service is terminated.

On the reverse side of the card, miscellaneous services not recorded elsewhere are listed. To the left are 3 columns, 1 each for date, type, and result of a test or service; the remainder of the space—over half the width of the card—is for remarks. Here may be summarized data on negative laboratory reports, negative X-ray reports, the issuance of health cards, and other limited services, and data on deaths.

The Family Folder

The family folder is a lettersize manila folder of special cut labeled to show the name of the head of the family. This size folder makes it possible to insert all records without folding and to include patient and family correspondence as well as service records.

Family Data Sheet

The family data sheet was designed as a separate record to permit the replacement of worn or soiled folders without the necessity of copying the information and to encourage the typing of the record, particularly the identifying information and family roster.

This sheet provides a summary of pertinent data on the family as a unit. Following a section for identifying information at the top of the sheet is a section for a complete roster of family members. After each name in this list is space for sex, date of birth, and changes in status, such as marriage, entrance into the armed services, or departure from the home for other reasons, by date.

A section on both sides of the form equivalent to a full page is provided for the narrative recording of significant economic and social data. In this section extra-family members living in the home are accounted for in terms of their influence upon the family life. If one of these members receives service, a folder is opened for him. The objective of this arrangement is to encourage the study of families as units.

At the bottom of the form on the reverse side is a section for the chronological summarization of the various services provided for individual members of the family.

Family Service Narrative

The family service narrative form is an 8½- by 11-inch sheet ruled on both sides. At the top is a space for family identification. In a column at the left are entered the date, place of visit, type of service, and individual served. Routines normally associated with the specific type of visit are recorded in a predetermined order set forth in the records guide prepared as a part of the project. This makes it possible to find these data without reading the complete narrative statement. Each narrative entry is signed by the person performing the service recorded. All visits to individual members of the family and to the family as a unit are recorded in chronological order on the same form. This system is an improvement over the old one, which provided separate forms of different types and often of different colors for each type of service.

Individual Observation Record

The individual observation record, an 8½- by 11-inch card, is used to record in chronological order data on all types of clinical services given an individual. It replaces the numerous forms previously used for the various clinical services. It contains sections for identifying information; medical history; disease experience; immunization data (for use in well-child conferences); findings, recommendations, and progress notes, by date and type of service; and results of laboratory and other tests, by date and type. Each entry in the narrative portion of this form—the section for findings, recommendations, and progress notes—is signed by the person performing the service.

Other Records

The tuberculosis program register and the orthopedic clinic record used in the earlier system were retained without change in the new system. The former, a visible file, is a modern and useful device for operating a tuberculosis program and is a permanent part of the new record system. The latter must be used until all counties served by the orthopedic clinic adopt the simplified forms.

Supplementary records giving detailed data are used when needed, particularly in the initiation of special programs. For example, in the nutrition program it is necessary to keep daily records of individual food consumption to determine nutritional patterns. These data are summarized on the family service narrative or on the individual observation record. Other forms, such as the laboratory form which accompanies a blood specimen to the laboratory and on which the laboratory findings are recorded, are destroyed after the results have been posted on the basic record cards, proofread for accuracy, and tabulated for reports.

The Filing System

A simplified system for filing the new service records was also developed. The master cards, which constitute the greatest volume and which are the records most frequently referred to, are filed alphabetically. Guide cards subdivide each group of approximately 25 cards. The cabinet is located beside the receptionist's desk, where the patients are registered, and is accessible to all staff members.

Active family folders containing individual observation records of family members are filed alphabetically in lettersize cabinets behind one-fifth cut guide cards. Alphabet guides are in the first position; guides with family names which occur most frequently or which are withdrawn and refiled most frequently, in the second; the family folder, labels, in the third and fourth; and "out" cards in the fifth. Immediately following the family folders are miscellaneous folders (for each alphabet letter) containing the individual observation records and correspondence for patients for whom there are no family folders.

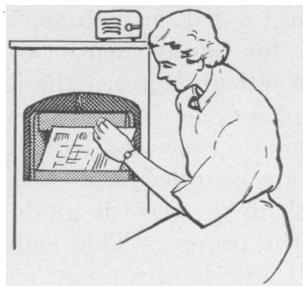
Inactive records are transferred to an inactive file set up like the active file. Pending files are used from time to time for groups of records withheld for completion of immunizations or for those used routinely in outlying clinics.

The System in Operation

In addition to the development of new forms and a new filing system, the records project included the study of such factors as the floor plan of the building, the position of furniture

Compact, Organized Central Records Room Facilitates Management

Located on the first floor of the health department, the records room, shown in the photograph, contains: (1) master card file; (2) visible file holding tuberculosis case register; (3) intercommunication system box; (4) dumb-



waiter for sending records to the second-floor nurses' office; (5) file for family folders and individual observation records; (6) file for discontinued records; (7) metal case for carrying records to outlying clinics; and (8) file for small and large X-rays. The sketch above shows a nurse in the second-floor office adjacent to the clinic receiving a record sent up in the dumbwaiter from the records room.

and equipment, and the location of lighting fixtures in relation to the flow of records and the routing of patients. As a result of a better understanding of these factors, the staff nurses voluntarily agreed to exchange offices with the receptionist in the interest of greater efficiency. To facilitate the flow of records, a dumbwaiter, designed by the health officer, was installed to carry records from the first-floor file room to the second-floor clinic.

The forms were used on a trial basis for 8 months. A preliminary guide to their use was prepared. During the trial period, staff members kept notes on problems encountered and offered suggestions for using the records more effectively. Periodic conferences were held to evaluate progress and to consider necessary adjustments.

Only a few minor changes were made in the forms, but a number of changes were made in procedure. The transfer of information from old to new forms produced the most difficulty and placed the heaviest burden on the staff. In May 1951, a manual of instructions incorporating the results of the preceding 8 months' experience was completed. This manual was prepared by the University department of field training.

The successful changeover from the old record system to the new was made possible through the combined efforts of public health workers from the district health department, the School of Public Health, and the State board of health, representing several different public health disciplines.

The results of this project have reached a great many people by various avenues. Students assigned to the health department for field training or for the residency program for medical officers have had an opportunity to see the system in operation. Seminars on records have been conducted for the students of the North Carolina School of Public Health as part of their study programs. The system has been

explained to visitors to the district health department. The district health officer reported on the simplified records at a meeting of the local health officers of the State. Similarly, the nursing supervisor discussed the records with the nursing supervisors of the State at an annual meeting. At the 1952 annual meeting of the Southern Branch of the American Public Health Association during the "curbstone consultation" session, the new system was explained by the nursing supervisor and by a records consultant from the State board of health. In 1953, experience with the new system was reviewed during a panel discussion on service statistics before the statistical and clerical section of the Southern Branch of the American Public Health Association. Copies of the manual of instructions with copies of the forms have been sent to public health workers in a number of other States and countries.

PHR *symposium*

Kanawha County, West Virginia

Coordinating Medical and Nursing Records

By L. A. DICKERSON, M.D.

THE NEED FOR a revision in the system of records and reports in use in the Kanawha-Charleston (W. Va.) Health Department was brought forcibly to our attention not long after consolidation of city and county units late in 1947. A short time after this merger, the local Visiting Nursing Association moved to affiliate with the official agency and to coordinate its nursing program with the official nursing program. Thus, the personnel, equipment, and records of three agencies were brought together in one location.

Within little more than a year after consolidation of these health units, the number of clinic services had more than doubled, with a corresponding increase in the case load. Specialized record forms were used for each of the clinic services, and the files were located in four different offices. Since no central index had been maintained, it was often necessary to search the files in each office in order to obtain complete information on patients receiving more than one service.

As a starting point in planning for a revision of the system, a record committee was selected from members of the health department. Included on the committee were the supervisor of nursing, the sanitation director, one clinic nurse, a records clerk, the administrative assistant, and the secretary to the public health director. Consultant help was sought and obtained from the State health department and from the regional office of the Public Health Service. Many meetings were held over a period of several months to decide upon the projected new record forms and procedures. Since provision for a health center was being made in a general hospital then under construction in another part of the city and only the clinic services were to be moved to this location upon its completion, it was decided that no attempt should be made to combine medical and nursing records, but instead to provide for interchange of infor-

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