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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mation between the two services. Sanitation records were already centrally located within the sanitation division and were considered to be satisfactorily maintained.

The objectives set forth by the record committee in its approach to the problem were:

1. To centralize in one record all medical information on each patient and to provide for interchange of information between medical and nursing services.
2. To eliminate duplication and unnecessary recordkeeping.
3. To reduce the number of record forms.
4. To establish a routine for followup of service where indicated.
5. To compile reports only on information that would be of use.

Many considerations of a practical nature entered into the thinking of the committee in striving for the attainment of these objectives. A majority of the clinic service records then in use were 5 inches by 8 inches in size but of different designs. A major complaint of personnel using these records had been that the same basic information on a given patient was recorded on several different forms. To meet this objection it was decided that a single form should be devised for recording all medical, social, and economic information needed on the patient, whatever the clinic service.

Clinic physicians had expressed a desire for a form with only a few general headings but with sufficient space for entering rather complete notes covering history, physical findings, and recommendations. Accordingly, a simplified history and physical examination form was prepared.

Three other forms that were considered essential were developed and adopted without disagreement. These provided for recording (1) all public health laboratory tests on a single form, (2) continuing observations and services, and (3) the public health nurse's report to the clinic. Provision was also made on the latter form for supplying information to the public health nurse as to physical findings and recommendations of the clinic physician.

Since an appreciable number of persons visiting the clinics received only screening tests, the need was felt for a form less expensive than a folder to record miscellaneous services other than services rendered by a physician. This consideration led to the adoption of a form which could serve as an index card and could also be used to record such miscellaneous services as laboratory tests, immunizations, and chest X-rays.

In order to utilize filing equipment then on hand and to make it possible to interfile old service records with the index cards, it was decided that this form should be 5 inches by 8 inches in size.

Forms and Rules for Use

The record forms that were finally adopted and the general rules for their use are as follows:

Index card. This card is completed for each person visiting the health center for service. A number is assigned to each individual at the time of the first visit, to be retained for all subsequent visits. For all patients not examined by a physician in one of the clinics, this will be the only service record.

Record folder. A lettersize manila folder containing the necessary basic forms is prepared for each individual to be seen by a physician in one of the clinics. A distinctive color tab is affixed to the folder to denote the clinic service. The individual's number, obtained from the index card, is entered in the upper right-hand corner of the record. Each folder has a pocket inside of the back cover to hold odd-sized, old record forms.

Forms Included in Record Folder

Five basic forms are included in the record folder:

Basic data form. This form provides space for recording all necessary basic information on the patient and members of his immediate family. It is completed for each individual at the time a record folder is initiated. When more than 1 member of a family visits the health center at 1 time, detailed information concerning the family is recorded for 1 member only and a reference note made on the records of the others.

Medical sheet. Pertinent history, physical findings, and recommendations are entered on

this sheet by the examining physician for all public health clinic services except tuberculosis, for which there is a special form. A few outpatient clinics require a special form in addition to the medical sheet and the tuberculosis form.

Laboratory report form. All laboratory reports are entered on this form except when laboratory tests are performed in the hospital laboratory. In the latter instance the original report is included in the record folder. Chest X-ray readings are sound recorded and transcribed directly to the laboratory report form.

Progress notes. This sheet is used by all workers in the health center to record their observations on or services to a patient. Social service and mental hygiene clinic workers record only a summary of their findings and recommendations on this form and keep a separate file of detailed case studies.

Nurse's report to clinic. This form is completed and sent to the health center for all individuals referred to the clinic by the public health nurse. It is also used to inform the public health nurse of the clinician's findings and recommendations for home care. When used for the latter purpose it is retained in the nursing record.

The basic data and progress notes sheets are stapled to the left inner side of the folder, with the basic data underneath. Staples are used here for economy, to reduce bulk, and also because there is usually no necessity to remove these forms from the folder.

On the right side of the folder a binder holds the remaining record forms in place in the following order from the top: medical sheet, nurse's report to clinic, correspondence, laboratory reports.

Appointment cards, tickler files for followup, and clinic route slips are also prepared. The route slip is attached to the record folder and serves to indicate the services to be received by the patient.

Changing to the New Record System

The date for changing from the old to the new system was set to be effective when clinic services were activated in the new health center.

Since the tuberculosis case load was one of the highest, it was decided to use the active register of these patients as a basis for converting old records to the new system. About 6 weeks prior to the proposed date of the change, an additional records clerk was employed on a temporary basis. This clerk reviewed the tuberculosis records and prepared a new folder for each active case, filing the old clinic record forms in the pocket inside the back cover of the manila folder. Each patient was assigned a permanent clinic number. Other clinic files in the department were searched for each patient whose record was transferred into the new system and, when other records of service to these patients were found, the various-sized old record forms were included in the pocket of the folder. No attempt was made to transfer detailed information from the old to the new forms.

The process of combining all records on active tuberculosis cases and entering them in the new record folders before moving to the health center constituted a trial period with the new system. This enabled us to make many adjustments in record procedures which contributed materially to smoothness of operation when the system later became effective for all service records.

Clinic equipment, personnel, and records were transferred to the new location, all services were discontinued for 3 days, and all active clinic records were moved into a central records office in the public health wing of the hospital. When operation was begun in the new location, all patients coming in for clinic services had records instituted in accordance with the new system.

As had been expected, several problems were encountered during the period of transition. However, most of these problems were minor in nature and were concerned with the routing of patients and flow of work. Somewhat detailed rules for use of the new records had been developed prior to their adoption, and these had been discussed in frequent conferences with all personnel using the record forms. Although an additional experienced clerk had been appointed for a 2-month period, the burden thrown on the chief records clerk was exceptionally heavy during the trial period when active tuberculosis records were being

converted into the new system. It was gratifying, however, to note that after a short period of experience, less time was required on the part of all concerned in maintaining the system. It has not been necessary to employ additional record personnel, although the case load remains at essentially the same level as it was prior to the institution of the new system.

With the exception of 6 lettersize filing cabinets, no major new equipment items were required.

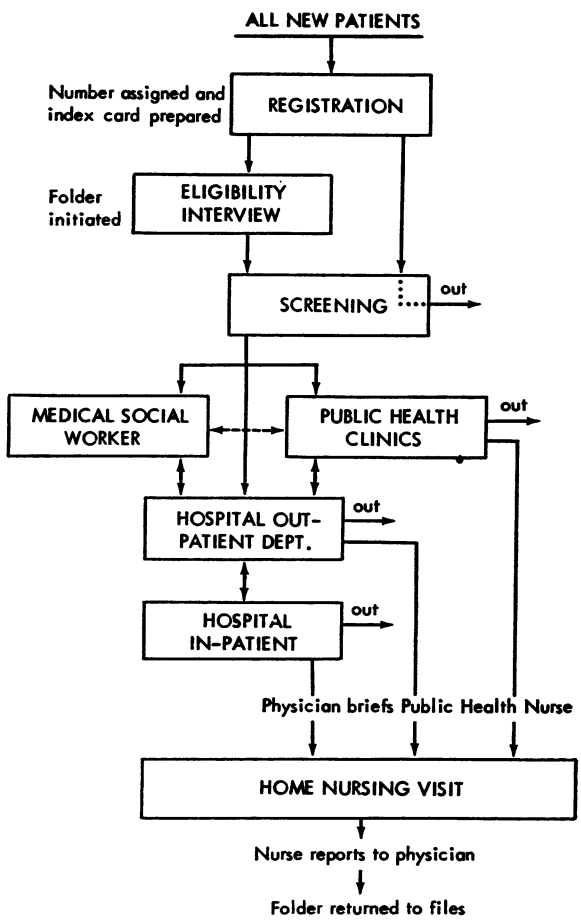
Cross-Referral of Records

Several months after the new record system was instituted, outpatient clinic services were established by the hospital in a separate wing. By agreement with hospital authorities, all new patients reporting for outpatient services are interviewed by health unit personnel and a decision made as to their eligibility for such services. Thus, the records for patients visiting the hospital outpatient department are initiated in the health center as well as those for patients visiting strictly public health clinics.

After registration, all new patients routinely have blood specimens drawn for a serologic test for syphilis and for dextrose determination and receive a chest X-ray. Those patients who are to visit an outpatient clinic are then escorted with their records to the outpatient department of the hospital. These records remain in the outpatient department, are filed there, and their location is shown on the health department index card. If a patient is referred back to one of the public health clinics, his record is requested from the outpatient department of the hospital and its whereabouts shown by an "out" card placed in the outpatient department file.

When a patient is transferred from one of the clinics into the hospital, a transfer form is executed and, in addition, the outpatient clinic record and/or public health clinic record is incorporated into the hospital record folder. Upon discharge from the hospital, patients who are referred for clinic service have their records made available to the outpatient department. When home nursing visits are requested, the nurse's report to clinic form is completed by the physician requesting the visit, and this form is retained in the individual's record of

Flow of patients and records, Kanawha-Charleston Health Department.



"Out" indicates home visit not necessary

nursing service. After making the home visit, the public health nurse uses this form to report to the clinic physician the observations made and services rendered. This report is then included in the clinic service record. The chart illustrates the flow of patients and records through the health department clinics and the hospital.

Since an index to the records of all clinic patients is kept in the public health unit, it has not been considered necessary to have a record index in the outpatient department of the hospital.

Tabulating Reports

In conjunction with the adoption of new record forms and procedures, a report form to be used as a daily work sheet was developed.

This form calls for a minimum amount of information on service provided the individual and on place of residence and is intended primarily for the information of local appropriating bodies. Certain additional information is compiled for maternal and child health and communicable disease services to be forwarded to the State health department. Reports are summarized once monthly. It is the belief of the Kanawha-Charleston Health Department that with this system professional personnel can obtain adequate additional information by an annual case-record review and by sample studies as the need arises.

Factors facilitating such reviews or studies are:

1. The distinctive color tab affixed to the folder to denote the clinic service or services which permits ready selection of records.
2. All services received by the individual complete in one folder or, if there is no folder, on one card.
3. Simplification of forms and reduction in their number, which reduces the task of extracting needed information.

Comment

Not long after the institution of this record system its advantages became apparent. Almost immediately satisfaction was evinced by all personnel concerned with medical and nursing records. In the 18 months that the new forms and procedures have been in use only minor changes have been necessary. Thus far no serious disadvantages have been found. One of the most important advantages noted is that the complete record accompanies the individual as he or she is routed for various clinic services. As a result, the work flow is smoother and the patient is served more effectively in less time than was possible with the old record forms and procedures. It is true that the index card has proved to be somewhat larger than necessary to record the required information on a substantial number of the patients reporting for service. However, this objection would seem to be overweighed by the advantage of being able to interfile index cards and old records of the same size.

PHR *symposium*

Portland, Maine

Reexamining Health Record Forms

By EDWARD W. COLBY, M.D., M.P.H.

RECORDS AND STATISTICS go hand in hand, but since records are the source of statistics, they are basic. If these basic records lack in quality, the conclusions drawn from them will be that much less valuable.

But however anxious we are to have usable records and the statistical data derived from them, to a goodly number the recording of information is a chore to be avoided. Why? Lack of time? Yes, to some extent. Lack of interest? Undoubtedly. Too much detail may require too much effort or the recordkeeper may discern no useful purpose for the information. Recording of information and data, unless carefully tended, may easily become merely a matter of habit. Like garbage, record procedures and forms must be reviewed and removed often to keep them from becoming obnoxious.

Change in Emphasis

It is generally agreed that records should be maintained for the purposes of: (*a*) providing the best possible service to individuals and fam-