TREATMENT PLANNING AND THE NURSING PROCESS IN PSYCHIATRY, USING THE PROBLEM ORIENTED MEDICAL RECORD FORMAT

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We hereby recommend that the thesis prepared under our supervision by Ann E. Frank entitled "Treatment Planning and the Nursing Process in Psychiatry, Using the Problem Oriented Medical Record Format"

be accepted as fulfilling this part of the requirements for the Degree of Master of Science.

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CHAPTER I

INTRODUCTION

The introduction of the problem oriented medical record by Lawrence Weed in 1968 and its subsequent adaptation to the psychiatric setting has brought a new awareness of the need for more systematic and multidisciplinary contributions to charting. The patient's record serves as a vehicle for his health planning, delivery of care, and follow-up treatment. The record has the value of a research, teaching, and evaluative tool, and serves as a guideline for future health care.

The problem oriented system has been described as a compilation of the problem oriented medical record which is both an audit tool and a feedback system. The problem oriented medical record is composed of data base, problem list, plans and progress notes. The progress notes are further defined to include subjective, objective, assessment and planning data.

The problem oriented record has received much attention throughout the health care field. Current literature is replete with favorable and unfavorable information on the problem oriented record. Many health care providers in varied positions have contributed to the ever growing number

of written communications, and most agree with the more positive view of its value. The problem oriented recording system has the endorsement of professional nursing organizations, such as the National League for Nursing and the American Nurses Association. When followed as intended, the problem oriented record meets the requirements of the Joint Commission on Accreditation of Hospitals, Standards I and II, for the hospital to continue as a viable, certified health care delivery system. This kind of recording brings accountability for paitent care "right down front" to be viewed by the consumer, consumer advocates, the care team, third party payment agencies, and organizations of internal and external hospital controls.

Many professional nurses, in order to keep abreast and take their places beside other professionals on the multidisciplinary team, have given up their traditional method of source-oriented charting, and now use the "Doctor's" progress notes for charting along with other members of the multidisciplinary team. Implicit in this is a more organized presentation of nursing data, reflecting observational and assessment skills. The organization of the nurse's thought processes, observational and writing skills, and the quality of content are all reflected in the progress notes for all who contribute to the record to see. The perception of the professional nurse as being able to make meaningful

contributions to the patient's records will now be magnified; in the past, the nurses' notes were compartmentalized and less likely to be noticed by other disciplines.

The hospital is still one of the places where multidisciplinary work can be developed and implemented. In the hospital setting the nurse has indirectly been a "SOAPER" all along, obtaining Subjective (S), Objective (O), Assessment (A), and Planning (P) data (SOAP). Now, involvement in the "SOAP" method of recording forces nurses to examine and compare current expectations of patient planning and recording with actual contributions of patient care planning and recording in a more systematized way. If a psychiatric nurse, or any nurse, is to function effectively as a team member, preparation must be adequate to be able to plan effectively, and the climate of nursing practice must be conducive to the encouragement of both personal and professional development to provide the best patient care possible.

The Professional Standards Review Organization (PSRO) legislation advocates the joint establishment of criteria and standards by medicine, nursing, and other health professionals to present a unified front to the public, and to the government officials who are overseeing the enforcement of the PSRO. A more specific purpose is to discourage the dichotomization of patient care planning by various health care disciplines. The Weed system has provided a tool for this

united effort in patient care by introducing a standardized, structured method that provides a series of actions or operations definitely conducive to an end, which is improved record keeping, and ultimately, improved patient care.

Documentation of patient care planning has become an integral part of individualized treatment planning. Simultaneously, with the utilization of the problem oriented record is the recognized need for all aspects of health care planning and delivery to be coordinated. Patient care planning lends itself well to the descriptive and structured recording set forth by Weed as well as to standards set forth by the Congress of Nursing Practice. The Committee on Standards for Psychiatric Mental-Health Practice (1973) stated that:

> The plan of nursing care will include goals derived from the nursing diagnosis, identifying priorities, and prescribe nursing approaches to achieve the goals. Clients can expect to be oriented to the plan of care as well as to collaborate in goal determination and in the determination of progress toward goal achievement . . . . . (pp. 1-6)

This study evaluated and determined the usefulness of structured documentation of patient care planning as opposed to documenting in an unstructured way. In this study, the structured manner was based upon Weed's "SOAP" method. The nurse's impact on the planning of patient care and the problem oriented medical record documentation was evaluated in this study.

Statement of the Problem

The patient's clinical record serves many purposes. Throughout the history of nursing, there has been much discussion concerning the inadequacies of the traditional patient record. Many of the inadequacies have been in the area of charting, and continue to exist today in spite of efforts to change them. One such effort has been the introduction of the Problem Oriented Medical Record (POMR or POR), which is utilized in many clinical settings throughout the country. The specific problem of this study was to peruse charting deficiencies on an in-patient psychiatric unit in the area of patient care planning.

Purpose of the Study

The purpose of this study was to compare documentation of patient care planning of traditional nursing records with documentation of patient care of the Problem Oriented Medical Record. Chart audit criteria were used as guidelines to carry out the purpose of this study. In addition an annotated bibliography was compiled for the reader's use (appendix A).

Background and Significance

The problem oriented system has gained a substantial following among health professionals in general medicine and psychiatry, although psychiatry was the slower to adopt it (Berni and Readey 1974). Some physicians have implemented

this more orderly form of charting in their private practices (Bjorn and Cross 1970). Extended health care facilities throughout the country have discovered the benefits of the "new" system, and adapted it to their own uses (Abrams, Neville, and Becker 1973). Current literature lists the adaptation of POR to many other services, both medical and business oriented. This form of charting is being practiced in several countries outside the United States of America (MacGowan 1975; Otway 1974; Valberg et al. 1974).

Funding, auditing, and utilization review committees, as well as legal mandates, have caused mental health professionals to re-examine the relationship of the patient's record to his care (Williams et al. 1974). Grant and Maletsky (1972) have described the basic format of the POR and its use on an in-patient psychiatric unit and comment favorably. Implementing the POR on a psychiatric in-patient unit requires considerable planning and staff training.

Changes often prove threatening, however, to persons concerned with the changes. Asprec (1975) proposed that any change affects people in three different ways; behaviorally, psychologically, and socially. Feelings of insecurity, trust apprehension, and expectations are often met with reactions of frustration and aggression, indifference, passive resistance or acceptance. The introduction of a different recording system may not only prove threatening to the security of

non-professional personnel, but to professional personnel as well. The change from the source oriented record to the problem oriented record requires much time and effort.

The advantages of the POR system far outweigh the amount of effort involved according to Williams et al. (1974), who implemented the POR on a short term psychiatric in-patient unit where treatment was provided primarily by nurses and psychiatric aides. It was found that informational deficiencies were more quickly identified and corrected. Treatment planning was more effective, staff skills improved, and the quality of patient care was more easily assessed. The POR was seen as a significant tool for coordinating patient care, for continuously up-grading the clinical skills of all mental health workers, and for auditing the level of patient care, staff skills, and staff education. The successful introduction and use of the system requires careful planning, on-going in-service, and staff willingness to account for their clinical care, implement change, and develop personnel skills. It calls for a clear commitment to its use by the unit leadership.

Weed (1968) introduced a method of charting that differed from the traditional method by the integration of narrative notations in a single section of the chart for all disciplines involved in the problem solving process. The chart is indexed according to specific guidelines.

The POR lends itself to meeting standards required by professional health organizations, medical audit committees, insurance companies, civil liberties advocates, private practice, and consumer demands. It brings together all participants of health care into the documentation process from the time of admission through discharge and follow-up care. This increases the value of each health team member by individual input of planning and implementing of patient care.

The POR raises other issues not directly addressed by the source-oriented records. Some of these issues are individual accountability (Valentine 1974), adequate preparation for a more systematic method of charting, cooperative spirit, recognition of the value of other disciplines, follow-up of patient care, awareness of professional standards, economics, and individual and disciplinary inadequacies.

Mazur (1974) pointed out that the professional encounter of a psychiatric patient, as opposed to that of a post-appendectomy patient, leaves no alternative but to anticipate and deal with the reality of preparing him upon discharge to face the stigma of having been a patient in psychiatric treatment. Mazur sees as part of the comprehensive treatment plan the preparation of the patient to handle the social stigma. He advocated the incorporation of the patient in planning his care and identifying his needs. This can be done in as many ways as innovative persons can imagine,

and successfully implement. He saw, however, that the use of identified assets in the assessment part of the SOAP format was the proper place for documentation. It has been found that in patient planning sessions, whether nursing oriented or multidisciplinary efforts, patients have responded with enthusiasm in identifying their assets. Also it was found that they had taken for granted certain skills and talents and had never attempted to assess them for use in problem solving.

Although the method in which information is recorded does not speak for its effectiveness, improved communication in recording ultimately should lead to improved patient care. It has been pointed out by Yarnall and Atwood (1974) that the traditional method lacked much of the necessary impetus for gaining many of the inroads for effective patient care that come with a method where there are established rules and guidelines.

There have been much time and effort spent by health care providers to master a system (POMR) that is directly related to patient care, but unproved in its effectiveness. Nursing is an active process. POR is also a process and a system. Application of any system in itself dose not activate the nursing process. Nursing has never been without functional guidelines. The POR system acts as a functional guideline. Nursing duties are defined by nursing standards.

The POR neither affects nor effects nursing standards without nursing activity. Nursing has always been an open system with many changing demands upon it. The time spent learning a new system for collecting, assessing, and applying data may be better utilized by focusing on the problems confronting nursing and the problem solving process.

There are many questions to be answered concerning the nursing process and the POR system. One of the many important questions may be if there is any real advantage to the use of the POR system in the nursing process. This study addressed that question. (See appendix B.)

Hypotheses

For the purpose of this study, the following hypotheses were formulated:

1. There will be no difference in the nature of nursing notations made on the patient's chart in the area of patient care planning after the implementation of the Problem Oriented Medical Record

2. There will be documentation of patient care planning on the traditional records before implementation of the Problem Oriented Medical Record

Definition of Terms

For the purposes of this study, the following terms are defined as follows:

Patient care planning: The systematic assessment and identification of patient problems, the setting of objectives and goals, and the establishment of methods and strategies for accomplishing them.

Documentation: Written nursing recordings claimed by a registered nurse (RN), by signature and title. The keeping of clinical recordings of the important facts about a patient and the progress of his health-illness states is called charting (Miller and Keane 1972).

Problem oriented charting: A narrative note organized by patient problem, consisting of problem name, subjective and objective information, and plan. The plan includes goals, actions, evaluation, and follow up on each stated problem (Larkin and Backer 1977).

Problem oriented records (POR): A part of the problem oriented system. "A method of modifying medical information to meet the basic standards traditionally accepted by science, common design, logical organization, elimination of guesswork, and usefulness for those within the profession" (Weed 1970, p. vi). For use in this study, the information focuses on nursing and the problem oriented record.

Problem Oriented Medical Record (POMR): Same as POR and for the purposes of this study, used interchangeably.

Traditional Charting (Source Oriented Records)(SOR): The non-integrated, chronological, narrative notations on the patient's chart dichotomized by discipline.

> For nurses this usually means that charting is done by hour of the day and by shift. Treatments and nursing interventions are charted as they take place. No systematic attempt is made to connect these with particular patient problems nor with the observations of the physician or other professionals. (Rieder and Wood 1978, p. 26)

Limitations

The limitations of the study were as follows:

1. Only one institution was selected for this study
2. Sample population included only psychiatric patients
3. Only entries by registered nurses were reviewed

Assumptions

The assumptions for this study were as follows:

1. Professional nurses and other disciplines were oriented and taught the principles of the problems oriented record system prior to the attempt to implement it on a psychiatric unit
2. The method of charting was not optional, but mandatory by hospital policy

Summary

The introduction of the POMR by Weed a decade ago provided a structured tool for the documentation of patient problem solving treatment, research, teaching, and administration. As a result of the proper use of the tool, the quality of patient care may be explored and evaluated on an on-going basis.

The POMR system has been adapted to psychiatry and extended to other areas. The changeover from the source oriented record to the problem oriented record has been tedious in certain areas, meeting with the usual resistance to change. It has been recognized that better problem management and better record keeping are being demanded by all concerned with legislating, receiving, delivering and paying for health care.

Chapter II is a review of the literature related to the problem area. In Chapter III the methodology utilized in the study is discussed. The analysis of data is addressed in Chapter IV and conclusions, implications and recommendations are found in Chapter V.

CHAPTER II

REVIEW OF THE LITERATURE

The review of the literature shows that much has been written nationally and abroad, in books and periodicals, lauding and criticizing the Problem Oriented Medical Record. The literature concerns itself with history, purpose, description, and implementation of the system. Many aspects of planning are enumerated in the literature, although problem oriented implementation of patient care planning is relatively unexplored and documented as a specific area of study. This literature review has been organized into the following sections: development, description of the Problem Oriented Medical Record, patient care planning, and implementation.

Development

Approximately eighteen years ago, the Problem Oriented Record (POR) was conceived and introduced by Lawrence Weed, a doctor of medicine and professor at the University of Vermont, College of Medicine, where he directs the Problem Oriented Medical Information System Laboratory (PROMIS). The Problem Oriented Record was first introduced outside the United States of America (Fletcher 1974) in the Irish Journal of Medical Science.

> Since his second paper published in this country in 1968, the POR has attracted widespread interest. . . . In five years it has received favorable editorial comment in major medical journals, and has been adopted by one or more departments of many American medical schools, and by many private medical care organizations; its use is encouraged by the American Board of Internal Medicine, and it has been marketed commercially.
>
> There is a growing number of journal articles and books about POR's. (Fletcher 1974, p. 829)

Kathryn Lambert (1974) states that the POR system "is much more than a method of record keeping; it is a whole philosophy of patient care. . . . it is a system which can be modified to meet the needs of a variety of settings" (p. 29). A proponent of the system (Walker 1973) records that the system is basically a simple and sensible method of organizing information for easy access to it, and keeping logical interrelationships among various data.

Description

The POR is complete and in working order when it provides for the following four components: the data base, problem list, plan, and progress notes. The first component is the data base. The data base is a collection of a defined body of information, gathered in the admission workup. Woolley et al. (1974) state that "problem parameters" should also be included. "Problem parameters" encompass all data, even though collected after the initial presenting situation, and are a part of the total data base; however, to distinguish their point in time, such data are termed a "problem

parameter." Included are the medical history and the physical examination, including the review of systems, the patient's chief complaint, and history of present and past illness, laboratory findings, special data collected by therapist and others, patient profile, and nursing history, social and family, and mental status examination. Information is also included from referring agencies, family, and/or friends. An incomplete data base retards the identification of problems on the problem list.

> When the defined data base is not complete, then problem #1 becomes incomplete data base. In such a case, an initial plan must be shown that will solve the problem. (Hurst and Walker 1972, p. 240)

The second component of the POR system is the problem list. It should reflect the reason the patient is seeking, or is in treatment. Weinstein (1975) writes that:

> A problem list identifies the patient's problems based on the original data base and subsequent information, and lists each of the problems in the form of a brief descriptive title, with a number, the date the problem was presented, and when appropriate, the date resolved. The problem number has no ordinal meaning, but serves as a sort of index in the record. Problems listed should be based on observed or reported situations, rather than on conclusions which involve intuitive impressions. However, where a conclusion such as a diagnosis appears with sufficient clarity, it can be included in the problem list. The problem which can be listed goes beyond the sphere which might be reflected in a medical or psychiatric diagnosis. (p. 457)

It could also include additions by any health care worker. The problem list is added to, re-defined, and updated as new problems occur, and previous ones are resolved. Temporary

problems, described as minor but persistent, recurrent problems, or controversial issues may be added to the problem list (Mazur 1974, p. 51). The list is helpful to the patient only if it is honest, accurate, and complete. Each problem should be defined at the level of sophistication of the recorder. In certain settings, nurses have not been permitted to define problems. However, nurses may be able to note role descriptions and functional levels, or write of problems in the treatment process such as "will not report for medications" or "will not keep appointments." Gilandas (1972) notes that "the care with which the problem list is constructed determines the utility of the whole record" (p. 337). The problem list may include problems identified in any area of the patient's life that causes disruption. These areas, for the psychiatric patient, usually include social problems; psychopathology in areas of thinking, feeling, self, sex, and so forth; family behavior; demographic data; and problems related to his religious beliefs.

The "P" represents the initial plan of care, the third component. After studying the problem list, and reviewing the patient's current status, the treatment team constructs a plan of action. Each problem should have a plan. The plan should consist of long and short range goals. Consideration must also be given to the needs of the patient's family. Many contributors to the POR literature explicitly state that

planning must include areas of diagnostic, therapeutic and educational orientation. Ideally, planning should be based upon contributions from the multidisciplinary team, who have collaborated with the patient and/or significant others.

> As information and treatment rationale are shared, it becomes increasingly evident that the responsibility for the development of treatment plans for specific problems can be delegated to team members possessing the knowledge and skill necessary in the planning and implementation of appropriate interventions. (Walter, Pardee, and Molbo 1976, pp. 115-116)

Many problems evolve during the planning phase: too much time spent charting and meeting, failure to have specific plans for treatment documentation, and criticisms of the system. There have been complaints cited of the inequities of the work load. Failure to meet as a team for updating and re-evaluation resulting in incomplete and non-therapeutic approaches to documentation have also been cited as problem areas.

Woody and Mallison (1973) see that setting priorities facilitates expediency and relieves unnecessary discomfort in planning for both patient and staff. The doctor's order sheet is an extension of the plan and should be numbered and titled according to the problem.

The progress note section is the mechanic of the POMR. Included are the subjective statement(s), the objective finding(s), the assessment(s), and the plan(s) which make up the narrative notations. The flow sheets and discharge summary

are included in the fourth and last section. Each note is numbered and the descriptive title is written for the particular problem under discussion.

The "SOAP" ancronym format is necessary when charting on the progress note. Weed has stressed that the "S" or subjective information should be first as the patient should be seen before the laboratory work or the X rays. Subjective refers to the problem or symptomatology as the patient or others significant to him express it. Included are statements about "his feelings or moods, activities, plans and concerns, as well as his evaluation of the treatment and his progress in resolving the problem" (Smith, Hawley, and Grant 1974, p. 21). If the patient or family member or referral source make no contribution to defining the problem, then "none" should be written following the "S".

The "O" is written for objective data descriptions which include clinical findings, staff observations, and statements. Objective information should be stated only in factual terms.

The "A" refers to assessment which is made after the subjective and objective information have been analyzed, synthesized, and conclusions have been drawn from them. This is the area that appears the most difficult for professional nurses. Woody and Mallison (1973, p. 1173) assert that since "assessment is the intellectual processing of an event, it

is the most difficult task for everyone, not just for nurses." Niland and Bentz (1974) have pointed out that assessment is a confusing word within nursing, and between nursing and other disciplines, it means different things to each individual. Many authors (Carrieri and Sitzman 1971; Griffith 1971; Little and Carnevali 1969) include assessment as part of the nursing process, but each describes it from a different perspective. The difficulty with assessment presents the greatest challenge to nursing documentation. It increases the nurse's satisfaction when that portion of the format is satisfactorily carried out. This is also the area that demonstrates to others the capacity of the professional nurse for analytical thinking, observation, and comprehensive documentation. Assessment may also be thought of as a diagnosis, an impression, or a condition change, for better or worse. Problems isolated in the history and physical data collection are used for the assessment (Berni and Readey 1974). "Don't know" is an acceptable assessment if the statement is true, stated gane (1973). "Deferred" may be used if some effort is intended to clarify and update the assessment when additional data are obtained. All assessment information should be substantiated by evidence.

The "P" represents the progress notes plan. The initial plan is based upon available data, and communicated in writing. It is the first plan written for each problem on the list. There is only one initial plan. All subsequent

entried in the progress notes under "plans" relate to re-assessing and updating identified problems or new problems. Berni and Ready (1974) equate the progress notes plan with the initial plan in some respects. Like the initial plan, the "P" on the continuing progress nots should also be considered as a potential threefold program of action: diagnostic, therapeutic, and patient education. Sometimes referral is included as a fourth component of the plan. Initial plans and continuing progress note plans are actually interventions, prescriptions or nursing orders in that they are statements of how to manage or intervene in the patient's problem(s), stating what is to be done, where, when, and by whom. Planning is enhanced by stating a point in time the established goal is expected to be met. Each component of the SOAP format is equally important, but is inadequate by itself. The four components comprise a workable guideline to better patient care.

The diagnostic aspect states what is planned in order to obtain more information about the problem if necessary. The therapeutic aspect includes what has been suggested or prescribed to alleviate, eliminate, maintain or control the problem, or how to learn new methods of coping with it. The patient education plan reveals all the information the patient and his family have received or should receive in relation to

his problems, and the treatment of them. Referrals, if needed, would include a plan describing the action taken to ensure follow-up of the problems. Unlike initial plans, progress note plans deal with the developing and on-going problem planning in response to "S", "O", and "A" conclusions. Niland and Bentz (1974) have stated that the problem oriented system can be used to implement the nursing process. It helps to organize and facilitate the planning process. It is recognized that whenever there is an organized system with established goals to be reached through implementation of that system, the continuity of that process is ensured. Therefore, it stands to reason that better nursing care planning of patient care can be done through awareness, implementation, and documentation of observational notes. Communication is vital as recording cannot be expected if there is no knowledge.

It is possible to chart on two or more problems in the same note. However, the problems should be reflected in the paragraph title (Atwood, Mitchell, and Yarnell 1974).

Flow sheets and summary statements are part of the progress notes. The flow sheet serves as the data collection record for pre-established parameters. Parameters are arbitrary constants whose values characterize the mathematical expressions into which it enters. Flow sheets structure the time dimensions of care. Each flow sheet is numbered and titled. They have the value of showing interrelationships

that might otherwise not be perceived (Walker, Hurst, and Woody 1973). The use of flow sheets avoids repeating similar data in the SOAP format. The flow sheets have been referred to as "shorthand" for progress notes. The flow sheet may sometimes be the only progress note necessary, and shows the patient's progress at a glance. Monson (1975, p. 52) suggests that "a flow sheet is only as good as its parameters. . . . progress notes should contain the assessment and the plans based upon data from the flow sheets." Flow sheets used in SOR were often considered separate divisions of the chart and not incorporated in the nurse's notes or the doctor's progress notes.

Summary statements, whether transfer, discharge or death notes, become a type of progress note providing a concise description of the patient's problems and a summary of the hospital course for each proglem. Problems to be summarized should include active or inactive problems for which action was taken during treatment, active problems that require continued treatment after hospitalization, and those that require special plans to prevent difficulty. According to Smith, Hawley, and Grant (1974):

> Inactive problems are simply listed by title either in the order of occurrence on the problem list or in a group at the end of the summary notes. If a problem has been redefined or updated, only the more current title is listed. (p. 19)

The summary statement is the final progress note. This progress note provides a means of communicating what has been done in the current treatment of the patient. It also reflects occurrences that will have some effect on the future management of the patient's problem(s).

The literature specifies a few simple rules for when and how progress notes in the POMR system should be written:

1. Each entry must relate to a specific problem and be signed and dated. The time of notation should be made, and the recorder's title should be included.

2. The source of data and the basis for decisions should always be indicated.

3. Whenever an abnormality appears in any of the parameters being documented, or whenever an unexpected observation occurs, a progress note to that effect should be written.

4. Whenever there is a change in the patient's condition (improvement or decline), a progress note should be written.

5. Whenever the plan of care is changed, the reason for the change must be documented. Once a plan of care has been established, that plan should remain in force until the assessment changes, or there is documentation that the plan is not working.

6. Whenever one type of therapy is not working, or the patient's condition remains unchanged for a predetermined length of time, a new assessment should be made.

Patient Care Planning

The patient care plan is determined by assessing the individual problems, assets, and goals. The purpose of care planning is to assist the patient with the identification of his problems, to make nursing assessments, and to decide, in advance, upon interventions necessary to achieve nursing care objectives. It consists of setting goals, weighing alternatives, proposing interventions, implementing, evaluating, and following up on an ongoing basis. Priorities must be considered and set up with expected outcomes. Planning should be time oriented; that is, expected outcomes must have some measurable point in time to enable the patient and the planners to measure the progress.

Planning is the first step of organization. Planning and organizing entails forethought and action oriented decisions. In order to plan for a patient, it must first be recognized that he is an individual, entitled to the best care that can be provided him. In order to intelligently plan the patient's care, it is essential to have an educational base for doing so, and even more helpful to have that base grounded in experience. Planning is necessary for effective action.

When planning patient care, the what, when, why, where, who, and how questions should be answered. Unless the plan is documented somewhere on the patient's record, there is no plan (Kron 1971).

Planning must not be done in isolation. It must be communicated with all health care planners and workers. Nursing shares roles and responsibilities with many other disciplines, but nursing has a unique role, one that it shares with no other health care discipline. It is the role of assisting a patient with his ongoing, minute-by-minute, day-by-day personal care maintenance, comfort, and safety that is unique to nursing. It is the essence of this role that provides the basis for effective patient care planning (Bower 1972; Kron 1971; Little and Carneval 1969; Mayers 1972).

Patient care planning begins with assessment. For each problem or potential problem, there is at least one statement of action or inaction. The purpose of the plan of care is to identify and describe nursing intervention for the individual patient. Once the nursing assessment is made and synthesized, the plans for nursing interventions or actions are written. An obvious reason for documenting planning is to guide and direct nursing actions so that the patient's nursing care objectives are achieved, and his health deficit or problem is corrected or alleviated.

Planning patient care should begin upon admission, after the nursing assessment. The nursing care planning should identify long range problems and nursing care objectives. The sooner long range objectives are identified, the sooner the nurse can begin planning with the patient and his family for his discharge. The discharge planning process should be early, and be ongoing. It has been stressed that discharge planning be added to the problem list as the need for the planning should be an early priority in the patient's treatment program.

A specific format for discharge planning known as METHOD was described by Cucuzzo (1976):

> M: Medication, those the patient is taking, including whether the patient is aware of their use, side effects, and any medication allergy.
> E: Economics, includes; consideration of the home environment, and possible problems with transportation for follow-up clinic visits, Medicaid, Medicare.
> T: Treatments to be done at home including consideration of the extent to which the patient can carry-on the prescribed activity.
> H: Health education, or general hygiene instruction.
> O: Outpatient referrals, includes extended care facilities, Visiting Nurse Association, ambulatory care.
> D: Diet. (p. 44)

When such planning begins early, the patient should experience a smoother transition from hospital to home or another health care facility.

Sometimes a plan may be to do nothing since action may not be warranted by the circumstances. The difference in the inaction is because the clinician knows and plans the

inaction, not because the clinician is unaware of a problem or does not know what to do. No time should be wasted writing something the clinician neither believes to be a problem, nor about which the clinician intends to do nothing.

Patient care planning need not be tradition bound. The Joint Commission of Accreditation of Hospitals has described nursing care planning as a necessary condition for the achievement of the basic goals of nursing (appendix C). The initial plan, the progress note plan, and the nursing kardex should all reflect the same basic concerns based upon interventions according to problems formulated.

Krall (1976) gave guidelines to writing mental health treatment plans. She asserted that the treatment plan should be written in behavioral terms. Precise goals should be stated, with the expected period of time for hospitalization. Specific measures to be employed in the problem solving process need to be included. She noted that "the emphasis in treatment is to look for behavior that is keeping the patient in the hospital" (p. 236). Writing plans in behavioral terms is a most difficult task; however, it is not as difficult when the recorder focuses on the action of the patient.

Ideally, the mental health planning team will set up guidelines for treatment. This team is composed of representation by a psychiatrist, psychologist, social worker,

nurse, group therapist, activity therapists, and others. Each discipline would be expected to contribute within the area of his expertise. It happens many times that the initial planning is left to (for) the nurse. The nurse then outlines the actions necessary to diagnose, teach, treat, or refer.

The name of the person providing the treatment should be indicated on the treatment progress note with the proper signature and title. The time of entry of the progress note should be made.

The need for psychiatric hospitalization often means that the patient is not functioning adequately in the home or community, or has displayed disruptive behavior. Traditionally, patients have not participated in their treatment goals. As McLean and Miles (1974) pointed out, patient involvement in problem identification

> . . . serves to enhance communication, maximize treatment efforts, and increase the probability that the patient will be able to generalize therapeutic gains to his environment. Furthermore, involvement of patient, family and/or significant other is essential to ensure that the description and nature of both problems and goals are in a language that the patient understands and agrees with, otherwise, the patient may be less capable and less inclined to participate in follow-up. Patients who are confused at the time their initial problem list is developed, can be involved in the problem list or its alteration upon improvement. Such involvement is typically therapeutic. (p. 623)

Treatment, or patient care planning should always be operationally defined in a standardized manner so that the

treatment can be replicated and evaluated by audit criteria. Progress notes relating to patient care planning should be expressed in terms of goal attainment for each of the problems, and criteria for terminating psychiatric treatment should be established in advance and be specified at the time the initial treatment plans are developed. Follow up should become a routine feature of patient care, and periodic checking should be done on an established time basis after discharge.

On her list of the disadvantages of problem oriented nursing, Malloy (1976) stated that the defining of the patient's status in terms of his problems emphasizes his disabilities rather than an accurate picture of both strengths and weaknesses. The possibility of this emphasis on disabilities has been considered, and many clinicians and writers agree that the identification and addition of the patient's assets balances any tendency to dwell only on the negative. Many times planners are able to recognize and point out resources that the patient is unable to recognize or value as an asset. It is important that the patient recognize that there are assets to assist in dealing with identified problems. It has been found that patients willingly and skillfully point out their own assets in relation to their problems.

> The psychological makeup of an individual includes a great number of items which strictly speaking are not normal. They differ from individual variations within

> the anatomic or physiological norm in that they cannot be assumed to be present in the majority of patients. Therefore, it is necessary to actively search for them and enumerate them in a manner similar to the construction of the problem list.
>
> Taking into account the assets of a patient is especially important in psychiatric hospitalization. In spite of the lip service paid to slogans which were devised to obliterate this prejudice, an individual who was treated in a psychiatric setting has problems that a post appendectomy patient does not have.
>
> In order to formulate a meaningful therapeutic strategy and plans for rehabilitation it must be taken into account not only the pathology, but also the forces working for recovery. Including positive factors, the patient's assets and resources offer a better chance of restoring health and re-establishing the illness-recovery equilibrium. (Mazur 1974, pp. 66-67)

Implementation

Implementation of the POR for an in-patient psychiatric unit created a problem for nurses (Williams and Debski 1974). The problem was in the form of resistance from other members of the multidisciplinary team, because of the lack of legal clarity of treatment and the threat of lack of confidentiality.

Novello (1973) described how basic components of the POR system could be adapted to psychiatry, and how it was successful using eight elements of the charting system. The elements were: (1) intake history, (2) planning conferences, (3) problem list, (4) progress notes, (5) progress charts, (6) flow sheets, (7) progress conferences, and (8) discharge conference. These elements can be further adapted to the process and practice of psychiatric nursing.

McLean and Miles (1974) explained various components of the POR in psychiatry and the importance of patient follow-up. They outlined six essential steps in the management of the POR in psychiatry. They have written that the POR's

> . . . potential yield to psychiatry threatens to be diluted considerably by insufficient attention given to conceptual and procedural issues involved in its introduction to the area of mental health. A disproportionate amount of staff time serves to retard the transition from traditional to POR maintenance, and if unresolved, places the POR's potential role in psychiatry in severe jeopardy. (p. 625)

Chappelle and Scholl (1973) have described how they adapted the records from a dietary service to the problem oriented record system. They utilized a temporary problem list and an asset list in their roles as dietitians in a state hospital.

Gerkin, Molitor, and Reardon (1974) have pointed out how the change from the traditional record keeping system to the POR system brought with it an awareness of its need to assess patients more frequently for needed continuation of hospitalization on an in-patient basis. Further, it was found that changing over from the traditional method to the POR system sounded easy, but in actuality, the treatment of psychiatric patients is so multifarious (behavioral and psychiatric diagnosis, social, vocational, educational, physical, legal, and areas of family problems), that planning becomes quite expansive.

The facilitators and implementors of the POMR system at the North Dakota State Hospital (Gilandas 1972) were enthusiastic because they were able to understand the rationale behind patient treatment. Consequently, in using the POMR, they experienced a greater share of the decision-making process.

POMR Studies

POMR studies have been cited by Berni and Readey (1974). They described a study of RN recordings on patient's charts before and after problem oriented charting had been instituted on the unit. An analysis of the data showed that problem oriented charting did not stimulate an increase in the quantitative documentation of the nursing process. The RN's on that unit were surprised to find that the problem oriented charting studied did not document their nursing process as well as their previous form of charting.

A pilot study of problem oriented nursing notes was outlined by Foss and Magill (1974). They reported who participated, how it was structured, and why it was done. They presented recommendations and future implications. They stated that dramatic improvements in almost all areas of charting were noted.

A descriptive study was done by Mitchell and Atwood (1975) to test the assumption that students developed the

ability to document more clearly, identify and plan to solve patient problems using the POMR format. There were no differences found between the groups in the mean number of patient problems identified from a care situation. However, in clinical charting, the problem oriented group identified significantly more patient problems and had significantly higher quality of organization scores.

Fletcher (1974) found no significant differences between performance of the POR and the SOR. Some difference in time involved auditing both records was found in the study to compare speed and accuracy with which records could be audited, measuring three dependent variables.

A comparative study of progress notes using problem oriented and traditional methods of charting was done by two groups of nurses from medical-surgical areas. One group had been taught to chart via the POR method while the other group used the traditional method. Several patient situations were presented. The nurses were asked to react to each situation by writing notes as though they were assigned to care for the patient. The study concluded with the null hypothesis rejected. The hypothesis was there would be no difference in the type of information recorded by those who had been previously taught the problem oriented method of charting and the type of information recorded by nurses who had charted in the traditional manner (Bertucci, Huston and Perloff 1974).

In a recent article Rieder and Wood (1978) described a study done at two Naval hospitals exploring the effect of problem orientation on a nursing staff's ability to identify underlying patient problems. It was found that there was a significant increase in the ability to identify patient problems after orientation to the problem oriented nursing format.

Advantages and Disadvantages of the POMR

The problem oriented medical record has been lauded for its advantages by many writers. A few writers have documented criticisms or cited disadvantages. Some of the same advantages and disadvantages have been stated numerous times in various ways. The list that follows summarizes the major advantages and disadvantages of the POMR system as found in this selected review of the literature. This list has been compiled to avoid repetition and to facilitate reading of the advantages and disadvantages as stated by different authors. Positive statement summarizations are given in the left hand column and negative statements are noted in the right hand column.

Advantages	Disadvantages
The POMR---	The POMR---
Facilitates reading about the progress of a problem and studying the relationship between problems on a patient's chart.	Violates a patient's confidentiality.
Saves time.	Uses more staff time initially.
Allows for planning of care in a logical manner.	Uses more staff effort initially.
Documents care given or not given and why.	Cuts into time for direct patient interaction.
Is usable in any health care setting.	Causes difficulty in separating objective findings from assessments and in conceptualizing the patient's overall clinical course.
Fosters versatility of system in other than health care settings	Effects fears of deficiencies in writing skills by some staff members.
Serves as teaching, research, and educational tool.	Fragments the patient and his problems.
Provides a method of current and retrospective evaluation of the services rendered.	Redistribute decision-making which may lower the quality of treatment.
Continues to function the same way regardless of changes in the membership of the health providers.	Loses focus on conceptual and procedural issues: a. diagnosis b. problem formulation c. patient involvement in goal formulation d. treatment e. follow-up f. progress notes and goal attainment
Identifies and corrects deficiencies (informational).	
Allows for more effective treatment planning.	Focuses on record more than patient.
Improves staff skills.	
Makes assessment of patient care easier to determine.	

Advantages	Disadvantages
The POMR---	The POMR---
Accepts additions to data base by any health care provider.	Creates rivalry among team members to be the one to define the problem and make the referral.
Effects more interdisciplinary collaboration.	Fractionalizes some problems.
Offers evaluative treatment rationale to entire staff.	Makes updating more difficult by change in treatment modality.
Prevents duplication of data.	Contributes to avoidance of staff to write the subjective aspects of the progress note, and use of terms such as "no comment," "no complaints," etc.
Facilitates faster retrival of information.	Provides for long bulky chart for long term patients difficult to sort out after many years.
Allows meaningful auditing.	Omits important highlights of nursing care or forces it into irrelevant SOAP format.
Aids in preparing insurance claims.	Requires disciplined, analytical thinking.
Helps in reviewing the appropriateness of treatment.	Views patients as a list of problems.
Exposes quality of patient management.	Causes the act of charting to become more important than the patient.
Structures progress notes to function as feedback.	
Organizes data for consultants.	
Facilitates the sharing in decision making.	
Promotes self-accountability.	
Functions as a work example that can supplement or substantiate for board examinations.	

Advantages	Disadvantages
The POMR---	The POMR---
Audits feedback mechanisms and allows objective analysis of various therapeutic techniques.	
Facilitates faster data retrieval from problem list indexed on front of chart.	
Gives a sense of team effort, achievement, mutual responsibilities, and respect to the initial treatment plans.	
Introduces new progress note including subjective which stresses the patient's personal appreciation and makes it difficult to ignore the patient's contribution and message.	
Improves patient care in direct proportion to the increasing competence of the treatment team.	
Defends against civil ligitation brought against members of the health care team.	
Meet requirements of JCAH and Medicare.	
Affords more meaningful assignments according to treatment rationale.	
Sets determination for treatment priorities.	
Anticipates treatment problems.	
Monitors staff performance.	

Advantages	Disadvantages
The POMR---	The POMR---
Categorizes assignments according to staff skills rather than professional discipline (more effective use of staff).	
Aids development of individual clinical skills.	
Allows better coordination of patient care.	
Facilitates ongoing training.	
"Accommodates itself to any theoretical interpretation of human dysfunction" (Gilandas 1972, p. 338).	
Compels supervision to be more meaningful.	
Makes it harder to hide mistakes.	
Makes it easier to notice excellence in staff performance.	
Capitalizes on several principles of learning: (a) active participation, (b) information feedback, and (c) individuation of instruction.	
Establishes concept of holistic patient care, not just medical or nursing care.	
Forces all data to be relevant.	

Summary

The literature reviewed indicated the need for a more systematized approach to documentation of patient care. A system was introduced that pointed up the accountability of health care team members for total care rendered. Descriptions were made by many health care providers with a consistency that made the POMR format easily recognizable.

Patient care planning was reviewed. Explanations of the process were presented. The expected participants were named. The need for planning, and how it could be done, were vividly presented in the literature.

Implementation of the POMR process was explained numerous times. The advantages and disadvantages of the system and process were pointed out. Many of the articles and studies reviewed stated distinct advantages. There were a few opposing views. However, most studies cited reported favorably of the POMR.

CHAPTER III

PROCEDURE FOR COLLECTION AND TREATMENT OF DATA

Introduction

The methodology chosen for this study was an exploratory review of the literature and medical records for the purpose of comparing documentation of patient care planning of traditional nursing records with documentation using the POMR system. The procedure for collection and treatment of data discusses the setting and population of the study and methods that were used for collecting and analyzing data.

Setting

The setting for this study was a 1,250 bed teaching hospital affiliated with a medical center in a large metropolitan city located in the southwestern part of the United States. The institution is federally funded. It includes in its services medical and surgical units, acute care units, ambulatory care clinics, nursing home care units, psychiatric care facilities, and other extended care facilities. Written permission was obtained to use this institution as the setting for the study (appendix D).

Population

The target population for this study was composed of psychiatric patients on a forty-nine bed in-patient unit. Thirty-five of the beds were set aside for drug abuse patients while the remaining fourteen beds were divided among patients with problems of alcohol abuse, personality disorders, borderline psychotic, schizophrenic, and patients participating in drug research studies. The thirty-five drug abuse patients were the focus of the study. The patients, at the time of the study, ranged in age from twenty-two to fifty-five years. The study took place over a six week period. The patients selected were chosen according to the following criteria:

1. Patients who were engaged in the in-patient drug treatment program

2. Patients whose treatment was expected to last a minimum of four weeks

3. Patients who were mentally and physically able to answer admission questions

4. Patients with in-patient records one year before implementation and records one year after implementation of the POMR (1974)

The sample was thirty charts with in-patient documentation from admission to discharge. The length of stay was not less than thirty days nor more than ninety

days. Equal numbers of POR and SOR charts were sampled on the same population.

Tools

An original tool (appendix E) developed by the hospital Nursing Audit Committee was modified by the researcher. The modified tool was used to audit documented patient care planning. The modified tool was validated by having the Nursing Audit Committee review it. Further modifications were suggested by the Committee, and incorporated (appendix F). Subsequently, the Nursing Audit Committee stated that the tool reflected the information base the researcher was seeking. The tool was then tested for the adequacy of construction by auditing six patient's charts by six different raters, and then correlating their findings. All raters were professional nurses on the in-patient psychiatry service. The findings of these raters were consistent with the evaluation by the Audit Committee. This validated checklist was used to gather information to evaluate the type of documented nursing assessments made in relation to the particular problems of patients in the treatment program.

Data Collection

Charts of patients currently engaged in treatment on one psychiatric unit were screened and selected if they met

pre-established criteria. The criteria were: (1) charts of patients currently on in-patient status who had completed the one week of orientation, met with a treatment planning group, and had a comparative old chart; and (2) a comparable old chart with documented treatment on the in-patient drug abuse unit at least one year prior to implementation of the POMR. Of the total census of forty-nine beds, patient eligibility was established by meeting the above criteria. Those patients were ruled ineligible that had: (1) no comparative chart, (2) insufficient length of hospital stay, (3) non-specific treatment plans written within the specified time limit of five working days after admission, and (4) charts that did not meet the time frame of one year prior to the implementation of the POMR system. This was an effort not to bias the study by the attitudes or motivations of nurses during the transition period. For this study, the participation of the patient was neither sought nor expected.

If the patient's chart under consideration met the criteria, then the chart audit would be conducted. The chart audit procedure was accomplished by using the chart checklist (appendix G). The patient's chart was checked for the desired information by the registered nurse raters over a six week period of time. Five modified Charting Audit Criteria forms were distributed to each of the six raters.

A total number of thirty charts were audited by the six professional nurse raters. Sampling was done on one shift only (7:30 to 4:00) in order to control for the many variables that all staff or rotating staff members would introduce.

Treatment of Data

Descriptive, nonparametric statistical techniques combined with graphs and charts were utilized to analyze the data, summarize it, and communicate the findings in sufficient detail. Frequency distributions and percentage techniques were included. Where appropriate, modified chi-square values were reported. The 0.05 level of probability was accepted.

Summary

An exploratory review of the literature and selected medical records was done. The setting was a 1,250 bed federally funded hospital located in the southwest. The population included the charts of thirty patients on an in-patient psychiatric unit before and after implementation of the POMR.

The original tool was developed by the hospital Nursing Audit Committee and modified by the researcher. The modified tool was used to audit documented patient care planning. Data were collected on thirty in-patients that met the pre-established criteria. The data were collected by

six professional nurse raters. Nonparametric statistical methods were used to assess the data. Chapter four will detail the findings of the data analysis using a modified chi-square formula. Tables will be included.

CHAPTER IV

ANALYSIS AND INTERPRETATION OF DATA

Introduction

This study was developed to investigate the difference in the documentation of patient care planning of traditional nursing records with documentation using the POMR system. The purpose of this chapter was to interpret the collected data from the Modified Chart Audit records. The data were categorized in order to better identify areas of planning to be addressed. The general areas identified on the audit screening criteria were: (1) admission, (2) nursing directives, (3) planning, and (4) documentation (appendix H). The frequency of responses were presented in a numerical manner with an overall percentage of differences between the number of positive responses before and after the introduction of the POR.

General Description of the Sample

The sample included thirty patient's charts on an in-patient psychiatric drug abuse ward that accommodated up to thirty-five drug abuse patients. The total capacity of the unit was forty-nine. All charts included in the study met the criteria stated in chapter III. The sample was

reviewed, tallied, analyzed and modified. The chi-square measurement known as the McNemar test for significance was applied (Siegel 1956). The McNemar chi-square test was designed to analyze the significance of the difference in two sets of scores from the same group of subjects. A fourfold table of frequencies represents the first and second sets of responses (60) from the same individual's in-patient charts (30). Positive (+) and negative (-) signs were affixed to determine different responses.

The McNemar test for the significance of change was chosen because the study used two related samples, was of the before and after type, and used nominal data (Siegel 1956). The level of significance was predetermined at a 0.05 level of acceptance. The critical value of significance measurement for each item on the Chart Audit Criteria form (30) for this study was found to be 3.86.

The null hypothesis stated that there would be no difference in the nursing notations made on the patient's chart in the area of patient care planning after the implementation of the problem oriented medical record charting system. It specified the direction of the predicted differences. The region of rejection was one-tailed. The region of rejection consists of all values of chi-square computed from modified chart audit data which was associated with their occurrence under the null hypothesis of 0.05 or less. A

difference was found and supported by the application of the McNemar test of significance, thus rejecting the null hypothesis and giving support to hypothesis one.

Hypothesis two stated that there would be documentation of patient care planning on the traditional records before implementation of the Problem Oriented Medical Record. Hypothesis two was supported by the data analysis which showed that of the comparative groups, traditional charting information was documented less frequently.

The data of this study are shown in table 1. This table shows that A equals the number of positive responses (yes) before the use of POR. There were 247 "yes" responses. The C window represents the number of positive responses for the same audit questions after implementing the POR (653). Windows B and D represent the "no" responses before (614) implementation and after (286) implementation.

TABLE 1

FOURFOLD TABLE OF RESPONSES BEFORE/AFTER POMR

	Yes		No	
Before	A	247	B	614
After	C	653	D	286

The number of positive responses changed from 247 to 653 after implementation of the Problem Oriented Record,

a numerical difference of 406. The percentage difference for increased documentation of patient care planning was shown to be 360%.

This study focused on the charts that showed changes in the positive responses before and after implementation of the POR as those represented in Cells A and C shown in table 1. A Table of Critical Values of Chi-square (Siegel 1956, p. 249) showed that when chi-square is equal to or greater than 3.84 and the degree of freedom is equal to 1, then the probability of occurrence under the null hypothesis is $p>\frac{1}{2}$ (0.05) which is $p>.025$, using a one-tailed test measurement.

Each question on the audit form sheet was tallied in a fourfold table using the rationale and method described by Siegel (1956) where it was suggested that when using the fourfold table, an individual is tallied in Call A if the change was from positive (yes) to negative (no) response. The tally is in Cell D if the change was from a negative one to a positive one. If no change is observed, the tally is either in Cell B (positive responses before and after) or Cell C (negative responses both before and after).

The McNemar test of significance was applied to each of the thirty questions from the charting audit criteria response and the fourfold tally table. Ranking of the questions in the order of significance is shown in table 2.

TABLE 2

RANKING OF NURSES' ASSESSMENTS FINDINGS FROM MODIFIED CHART AUDIT CRITERIA

Question Titles from Charting Audit	Significance Ranking
11. Valuables	20.0
28. Discharge Planning	20.0
6. Allergies	19.0
21. Intervention or Statement of Inaction	19.0
8. Prosthesis	18.0
9. Suicide Assessment	18.0
26. Patient's Current Condition	18.0
7. Medications	17.3
16. Plan relevant to Subjective/Objective Data	16.0
29. Discharge Plans Stating Instructions and/or Family Involvement	16.0
5. Mental/Emotional Status	15.4
4. Physical Condition	13.4
12. Subjective Data	12.5
30. Post Hospital Plans	12.0
1. Admission Note	12.0
15. Nursing Plans	11.5
10. Family	11.2
14. Nursing Assessment of Problem	10.0
19. Nursing Instruction	9.0
24. Results of Plans	8.6
17. Nursing Directives	7.6
25. Revision/Updating Plan	7.5
18. Need for Further Data Collection	7.1
23. Documentation of Plan	6.7
13. Objective Data	4.9
20. Patient Education	4.0
22. Plan Implementation	1.4
27. Referrals	0.75
3. Duration of Problem	0.16
2. Problem Identification	0.0

McNemar significance score for this test ≥ 3.86. Titles and numbers below broken line found to be non-significant.

A significant difference based on the findings of the study was found between the hospital admission prior to the use of the POMR and the hospital admission after the implementation. The above findings make it possible to reject the null hypothesis which states:

There will be no difference in the nature of nursing notations made on the patient's chart in the area of patient care planning after the implementation of the Problem Oriented Medical Record charting system.

Summary

A significant difference based upon the results of the study was found between the hospital admission prior to the use of the POMR and the hospital admission after implementation of the POMR, based upon the findings of the McNemar test for significance. The sampling described in chapter III, frequency tables, and the modified chi-square formula (McNemar) were used to test, measure, clarify, present, and explain the findings of the study.

Ranking of the questions in the order of significant findings showed that there were many high and low scores in all four categories. The four scores found to be non-significant were questions #22 (Plan Implementation), #27 (Referrals), #3 (Duration of Problem), and #2 (Problem Identification). This implies that these areas were

frequently neglected both before and after implementation of the POMR. Implications, recommendations, and conclusions will follow in chapter V.

CHAPTER V

SUMMARY, CONCLUSIONS, IMPLICATIONS, AND RECOMMENDATIONS

Introduction

This chapter reviews this POMR study and summarizes the progression of the POMR from its introduction over a decade ago until the present time. Conclusions are made by reviewing the data collected. Implications for the process of nursing are addressed. Recommendations are made for further study.

Summary

The review of the literature shows that in 1964 Lawrence Weed, M.D., first presented a description for recording clinical information that he called the "Problem Oriented Medical Record" (POMR). Four years later, the POMR was introduced in the United States and has become increasingly popular. The purpose of the introduction of the new system was to offer an alternative to the traditional source oriented diary approach to record keeping (SOR). The record is not to be seen as an end in itself, but as a means of organizing the data collection process and planning patient care to achieve important outcomes in health care delivery.

Four components of the POMR system were described. They are the data base, problem list, plan and progress notes. The data base is the patient profile, and contains information such as past health history, family health history, physical examination, physiologic data, laboratory data, nursing history and nursing observations about the life-style and current status of the patient. Acquisition of the data base is seen as problem seeking as opposed to problem solving. It is expected that there should be contributions to the chart data base by an interdisciplinary staff. The patient should always be invited and encouraged to contribute to the recording of his data base and on-going treatment progress. The complete and well defined data base is essential to the identification of problems. A problem denotes some aspect of the patient's health or environment causing disruption or the threat of disruption in his life or anything about the patient that bothers the therapist. Temporary problems are dealt with in the progress note, but they may be added to the main list of problems if they persist or develop into more serious or lasting problems. The problem list serves as a brief index of important abnormalities needing attention.

The problem list should give priority to those problems needing attention and/or treatment at the present time. Problems may be first designated as signs and symptoms,

and then evolve into diagnoses as more data are collected. Persons allowed to contribute to the problem list varies from setting to setting. On Psychiatry, all health providers are encouraged to contribute to the problem list according to his own knowledge base and perspective. The physician remains ultimately responsible for coordinating the POMR. The problem should always be formulated honestly, accurately, and as comprehensively as the data base permits, and as quickly as possible.

The plan: Each problem requires a plan. Ideally, the planning should include the patient and health care providers from all disciplines. This enhances communication so that decisions and care can be coordinated at the initial planning. The plan should specifically outline actions related to diagnosis, therapeutic intervention, education, and designate the person(s) responsible for implementation. The plan should include short and long range goals. Discharge planning should be included at the onset of admission. This treatment plan may be separate or written out on the progress notes as the initial plan.

Progress notes: Each notation is numbered and addressed by problem title. The "SOAP" acronym stands for Subjective, Objective Assessment and Plan. Subjective data can be obtained by listening to the patient and/or significant others to him, and by history. Objective data is

gained by observing the patient, physical examination and laboratory data. Assessment refers to analysis of the patient's problems summarizing the subjective and objective data. Plan: This is not the initial plan, but an extension of the initial plan, an additional step. Frequency of charting is designated by the institution. However, it is prudent to set minimal charting standards. It is not essential to have each component of the SOAP format recorded each time. When a note is written, two problems may be addressed in the same note. The title of the note should reflect what is being done. A flow sheet is an important part of the progress note. It is used to record certain data or parameters of a problem that reoccur and need to be recorded repetitively. The flow sheets can be designated to serve in varied settings.

The purpose of patient care planning is to make assessments and to decide, in advance, the interventions necessary to achieve the objectives. When planning patient care, the questions what, when, why, where, and who should all be answered. The emphasis here is on patient care, not medical or nursing care. Treatment planning is most comprehensively done by an interdisciplinary staff while patient care planning is a daily function of the nursing staff.

To answer the research question under study, a descriptive study was implemented. The setting of the study was an in-patient psychiatric, drug abuse ward in a large federally funded hospital in the southwest.

Conclusions

Based on the findings of this study, the following conclusions are stated. The information from cited readings suggest that implementation of the POR begins with oneself, and/or interested associates. Education and training are essential and should be on-going. The POMR is a useful tool for testing or auditing. The documentation by the professional nurse accounts for a large portion of the documentation, and is indispensable when documenting nursing history. No other health care discipline spends as much time with the patient as does the nursing staff.

The system should not be attempted in total, but introduced in part. If the system is effectively implemented, it will call attention to itself and be more readily adopted by others. The change should be developed, not forced.

Implications

Two of the non-significant scores dealt with problems (problem identification, and duration of problems). This might imply that nurses are either not comfortable or not prepared to make nursing diagnosis. A fear might be that it

would be "labeling" patients. It is apparent that many of the professional nurses are not attuned to problem statements by behavioral objectives. It is further implied that ways to meet these assessment and documentation deficiencies must be found.

Referrals are not being done with each patient as indicated by nursing and JCAH standards. Nurses must become more knowledgeable in this area. Awareness of inter-hospital and community resources and ways to effect the transition must be applied. Open and frequent communications with the unit level social worker is most important.

Implementation of the plan and documentation of it is at the heart of the process. The most elaborate and well defined plans are without any value unless they are carried out. Implicit here are nursing actions and communication of those actions by proper documentation.

This study uncovered deficiencies in methods and procedures. It revealed a need for change or revision of tools and/or methods. It pointed out the need for the constant element of evaluation. The implications for staffing were that with the multiple assessments, more meeting and writing time is required. More time will be needed for planning. Improved staffing would be necessary to allow time for proper documentation. It will be as important to document the activity or observation as it was to get it done. That

principle must be emphasized and reemphasized. If additional staffing cannot be arranged, then the implication would be to organize the staff and the work for better utilization of the available nursing staff. The relief of some of the professional nurse's duties might be handled by a Unit Manager to allow nurses more time for patient assessments and planning.

Other implications are for teaching and research from a unit level to systematic and comprehensive programs throughout the hospital complex. The information from this study should be shared with nurses engaged in the POMR process. There is also the awareness on the part of all team members that each has a responsibility to communicate more fully with each other, and to change the tradition bound relationships of the past.

Recommendations

The health care system is changing every day. The problem oriented approach has brought attention to the importance of the professional nurse to the interdisciplinary team. In the future, it is suggested that nurses:

1. Contribute more in-put into the treatment decisions that affect the patient

2. See that there is better utilization of clinicians, practitioners, primary nurses, nurses in traditional roles, out-patient clinics, and other nurses in expanded roles

3. Become self-assertive to implement their roles

4. Practice more positive role modeling

5. Conduct unit level and hospital-wide research, and communicate same

6. Do further research with this study using larger samples to confirm the implied differences and ascertain better utilization of existing resources

7. Closely supervise POMR follow-up

8. Plan and attend workshops, lectures, informal discussions, and seminars to include all disciplines and non-professional health care workers

9. Encourage more and better interdisciplinary staff participation

10. Become primary developers and implementers of new programs for patient care to meet standards of accreditation utilizing the POMR

11. Expect and prepare to deal with resistance to positive role modeling and self-assertion among non-nurse health practitioners

12. Identify and finalize the nurse's role on the POMR team

13. Keep in mind the individual patient differences, and the sociocultural determinants of problems addressed not only in clinical practice, but in other areas that provide education of nurses

14. Give input and participate in on-going education and/or training for patient and staff education

15. Propose more relevant programs to accommodate patient's needs

16. Take time for study, planning, and preparing materials

17. Propose that the claim "Doctor's" be removed from the progress note if it is intended that all disciplines share in the recording of the patient's progress and be recognized for their contribution

18. Study and propose ways to enhance interdisciplinary communications

19. Designate a person on each ward to be responsible for assessing and teaching the POMR

20. Do more comprehensive charting in areas of problem identification and problem solving

21. Request in-services on problem solving, writing behavioral objectives, problem assessment, and documentation

22. Become involved with a discharge planning committee or set up one to assure that referrals are made for each patient requiring such a service

APPENDIX A

ANNOTATED BIBLIOGRAPHY

Books

Abdulla, Faye, and Levine, Eugene. Better Patient Care Through Nursing Research. New York: Macmillan Co., 1965.

Presents the basic concepts of research in nursing particularly those concerned with patient care and an overview of what is involved in the research process. Discusses how some of the important methodological tools can be applied to problems that are unique to nursing. There is an introduction to research in nursing, a description of research methodology, a discussion of the methodology and findings of numerous research projects in nursing, and a review of the status of nursing research.

American Nurses' Association. Standards of Psychiatric-Mental Health Nursing Practice. Kansas City, Mo.: American Nurses' Association, 1973.

The purpose of standards of psychiatric nursing practice is to fulfill the profession's obligation to provide and improve this practice. The standards focus on practice. They provide a means for determining the quality of nursing which a client received regardless of whether such services are provided solely by a professional nurse or by professional nurse and non-professional assistants.

Berni, O. Rosemarian, and Readey, Helen. POMR Implementation: Allied Health Peer Review. St. Louis, Mo.: The C. V. Mosby Co., 1974.

Describes POMR system and discusses system implementation, evaluation, modification, and computerization. Presents system implementation model.

Bjorn, John C., and Cross, Harold D. The Problem-Oriented Private Practice of Medicine, A System for Comprehensive Health Care. Chicago, Ill.: Modern Hospital Press, McGraw-Hill Publications Co., 1970.

Discusses the usefulness of the POR in private practice. It provides for structure for systematic practice according to planned treatment toward a predetermined goal.

(In foreword) Lists eight determinants of a "sick health care system." The book would suggest the POR as a means to amend same.

Bower, Faye Louise. The Process of Planning Nursing Care. St. Louis, Mo.: The C. V. Mosby Company, 1972.
Discusses planning individualized care identifying nursing problems, selecting nursing actions, formulating evaluative criteria, and implementing the nursing care plan.

Easton, Richard. Problem Oriented Medical Record Concepts. New York: Appleton-Century-Crofts, 1974.
Discusses difference between source-oriented and problem-oriented patient care record, problem list, and data base concepts. Discusses components of patient care note, problem types, flow sheets, problem oriented patient care instruction, non-problem data, and audit concepts.

Fox, David J. Fundamentals of Research in Nursing. 2d ed. New York: Appleton-Century-Crofts, 1970.
A book intended to provide necessary concepts to read, evaluate, and write research literature.

Froebe, Doris, and Bain, Joyce R. "Problem Oriented Records and Quality Assurance." In Quality Assurance Programs and Controls in Nursing. St. Louis, Mo.: The C. V. Mosby Company, 1976. pp. 60-66.
Stresses the quality of entry into the POR as opposed to the quantity of information. Explains how the POR provides a mechanism by which improved communications are presented in a more organized format. This makes data retrievable. Illustrates quality assurance packages based on POR.

Gane, Donna. "The Problem Oriented System and the Practice of Nursing. In Applying the Problem Oriented System. New York: Medcom Press, 1973.
Explains how problem orientation affects nursing. Relates a Head Nurse's experience in effecting change and influencing others. Answers many questions regarding the implementation of the system and the reasons why. States benefits derived from its use. Shares implications for nurses for the future.

Hurst, Willis J., and Walker, Kenneth H. The Problem Oriented System. New York: Medcom Learning Systems Medcom Medical Update Series, 1972.
Explains POR including background information, practical considerations, educational and nursing implications, ambulatory care, patient care, private practice, and continuing education. Discusses the use of the computer and the POR system and the future.

Johnson, Mae M.; Davis, Mary Lou C.; and Bilitch, Mary Jo. Problem Solving in Nursing Practice. Dubuque, Iowa: Wm. C. Brown Co., 1970.
Discusses overview of problem solving, patient problems versus nursing problems, problem assessment, problem statement, and solving the problem.

Kron, Thora. The Management of Patient Care: Putting Leadership Skills to Work. 3d ed. Philadelphia, Pa.: W. B. Saunders, 1971.
Emphasizes the responsibilities inherent in becoming a leader and provides guidelines for the many ways leadership can be exercised in nursing practice. Focuses on planning efficient care, implementation, carrying out the care the nurse determines as necessary. Gives the principles of team nursing and describes the role and responsibilities of each team member.

Lambert, Kathryn. The Problem Oriented System as an Aid to Improved Interdisciplinary Planning and Evaluation of Patient Care. NLN Publication #20-1546, 1974.
Discusses the basic principles and use of the system. Differentiates between the POR and PO system. Addresses audits. Discusses the efforts of nursing education to translate the problem solving process into nursing service by use of the care plan which has been in use for many years.

Larkin, Patricia D., and Backer, Barbara A. Problem Oriented Nursing Assessment. New York: McGraw-Hill, 1977.
A workbook primarily aimed at student nurses, but it is also useful to any practicing nurse. It presents a way of reviewing and implementing the nursing process while gaining familiarity with the problem oriented system and examining interviewing skills.

Little, Dolores E., and Carnevali, Doris L. Nursing Care Planning. Philadelphia: J. B. Lippincott Co., 1969.
Discusses current concepts, rationale, philosophy, processes, nursing history, nursing care plans revisions of nursing care plans, teaching, and planning of nursing care.

Marriner, Ann. The Nursing Process: A Scientific Approach to Nursing Care. St. Louis, Mo.: The C. V. Mosby Co., 1975.
Presents a compilation of various theoretical concepts listing and explaining the four parts of the nursing process: assessment, planning, implementing and evaluation. Selected readings and an annotated bibliography complete the book.

Walter, Judith Bloom; Pardee, Geraldine P.; and Molbo, Doris M. Dynamics of Problem Oriented Approaches: Patient Care and Documentation. Philadelphia: J. B. Lippincott Co., 1976.

The content and goals of this book have been stated to be that a logical, rational basis for nursing practice can be developed and demonstrated with the Problem Oriented approach as the tool and problem solving, the process. The book outlines concepts, theories, implementation and expansion of the problem oriented approach.

Weed, Lawrence. Implementing the POMR. Edited by Guy S. Wakefield and Stephen R. Yarnell. Seattle, Washington: Medical Computer Services Assn., 1973.

A How-to manual for implementing the POMR system.

_____. Medical Records, Medical Education, and Patient Care. Cleveland: Case Western Reserve University Press, 1970.

Gives a detailed description of the POMR. Implication, medical responsibilities, explanation of computerization of the medical record, and case examples in large appendices are also found.

Weinstein, Abbott. "Evaluation Through Medical Records and Related Information Systems." In Handbook of Evaluation Research. Edited by E. Struenning and M. Guttentag. Beverly Hills: Sage Publications, 1975.

Reviews the POMR in order to evaluate it as an overall service program. Follows up with information of medical records automation.

Woolley, F. Ross; Warnick, Myrna W.; Kane, Robert L.; and Dyer, Elaine D. Problem Oriented Nursing. New York: Springer Publishing Co., 1974.

A book addressed specifically to nurses in all work capacities. It also invites student nurses to consider the POR as a concept to be broadly utilized. Provides a model for application, includes review exercises and examples of flow sheets. Presents three case studies for review exercises.

Yura, Helen, and Walsh, Mary B. The Nursing Process: Assessing, Planning, Implenenting, and Evaluating. New York: Appleton-Century-Croft, 1973.

Discusses components of nursing process.

Articles

Abrams, Kathleen S.; Neville, Robert; and Becker, Marjorie C. "Problem Oriented Recording of Psychosocial Problems." Archives Physical Medicine and Rehabilitation 54 (July 1973): 316-319.

Describes a set of guidelines developed for the Parkview Rehabilitation Unit (Ann Arbor) to describe patient behaviors, psychological and social problems more specifically and objectively applying the POMR format.

Asprec, Elsie S. "The Process of Change." Supervisor Nurse 6 (October 1975): 15-24.

Outlines difficulties effecting change. Gives some of the reasons why. Offers clues to increasing the probability of success.

Atwood, Judith; Mitchell, Pamela H.; and Yarnall, Stephen R. "The POR A System for Communication." Nursing Clinics of North America 9(2)(June 1974): 229-234.

Very brief history. Uses general questions about the POR as guidelines for planning. Points out difficult area of communication and various relationships in the regard to communication, considers time element in implementation points out advantage "payoffs." Discusses planning in detail.

Badgley, Robin F.; Ladd, Katherine B.; Levin, Lowell S.; MacDonald, Katherine; and Parrish, Henry M. "How Good Are the Records Your Agency Keeps?" Nursing Outlook 10(2)(1962): 118-119.

Study of agency's records revealed incompleteness in recording, inconsistencies in use of family folder, and ambiguity in definition of terms.

Bertucci, Madeline; Huston, Mildred; and Perloff, Evelyn. "Comparative Study of Problem Oriented and Traditional Methods of Charting." Nursing Research 23 (1974): 351-354.

The study compared problem oriented and traditional methods of charting by two different registered nurse groups. A five scoring criteria were used to evaluate the nurses' findings. The results are reported.

Bloom, Judith T.; Dressler, Joan; Michele, Kenney; Molbo, Doris; and Pardee, Geraldine. "Problem Oriented Charting." American Journal of Nursing 71 (November 1971): 2144-2148.

One of the earliest writings by nurses of the POMR. Discusses systematic method of organizing nurses' notes around the patients' problems by commenting on objective

and subjective observations, nursing impressions, goals, action taken, evaluation.

Bloom, Judy; Molbo, Doris; and Pardee, Geraldine. "Implementing the POR Process in Nursing." Supervisor Nurse 5 (August 1974): 24-38.
Cited experience of implementation in the hospital of POMR system. Behavioral objectives statements were incorporated in nursing care plans. Emphasized that the system serve the nurse, not nurse serve the system.

Carrieri, Virginia K., and Sitzman, Judith. "Components of the Nursing Process." Nursing Clinics of North America 6(1) (March 1971): 115-124.
Authors gave a vivid description of the nursing process. Included in the article was a description of daily recordings of all observations, inferences, diagnoses, actions, and evaluation in sequence. Both theory and practice in the care of patients undergoing cardiac valve replacement were used.

"The Challenge and the Opportunities of the Weed System." Archives of Internal Medicine 128 (1971): 832-834.
Weed actively influenced record keeping physically and psychologically, stating that the only way anyone would know what a physician thinks, plans, and does with his patients is to have it written down.
Also points out that although the beginning was slow, the POMR system has subsequently been adapted in the private practice, and hospital national teaching conferences have been held by proponents of the system (Hunt and Emory).
Weed agrees that his system is what he sees to be a technique for clinical record keeping.
Organized thought--Organized care.
Advantages:
1. Computerization of the patient's data base
2. Information and the development of an up-to-date national library of clinical medicine
3. Provides a systematic way of monitoring and auditing of medical care

Chappelle, Mary L.; Scholl, Ruth. "Adapting the Problem Oriented Medical Record to the Psychiatric Hospital." Journal of American Dietetic Association 63(6) (December 1973): 643-645.
In January 1972 Osawatomie State Hospital adopted the POMR system. Several changes were necessary for the psychiatric setting. This paper describes the use of a temporary

problem list, an asset list, and the role of the Dietary Department and the dietition in this new system.

POMR requires that evidence and observation be separated from opinions and interpretations in writing progress notes.

Cucuzzo, Rosemarie A. "Method Discharge Planning." Supervisor Nurse 7 (January 1976): 43-45.

"METHOD" discharge planning is described and examples are given. Adaptations of some POMR elements to improve planning for patients prior to discharge are given.

Feinstin, Abbot R. "The Problems of the POMR." Annals of Internal Medicine 78 (1973): 751-762.

Points the different advantages and disadvantages of the POMR as he sees them. The paper is oriented to teaching of aspiring doctors, therefore some of the points cannot be well taken as applies to nursing using the POMR.

In comparing the old style source oriented record with the POR, the author asks if renewing interest and energetic supervision of the old style might not give the same results.

Fletcher, Robert H. "Auditing POR and Traditional Records." The New England Journal of Medicine 290(15)(11 April 1974): 829-833.

A study to compare the speed and accuracy with which records could be audited measuring three dependent variables. Findings presented.

Foss, Barbara, and Magill, Kathleen. "A Pilot Study of Problem Oriented Nursing Notes." Supervisor Nurse 5 (August 1974): 47, 50-53.

This study demonstrated how the Weed system was adapted to nurses' charting, who participated in the study, how it was structured, and why it was done. Recommendations were made and future implications stated.

Garant, Carol. "A Basis for Care." American Journal of Nursing 72 (April 1972): 699-701.

Suggests how to systematically observe and document patient's behavior as a basis for care plan.

Geitgey, Doris A. "Self Pacing: A Guide to Nursing Care." Nursing Outlook 17(8)(1969): 48-49.

Discusses "SELF-PACING" as an acronym for systematic assessment.

Gerken, Betty; Molitor, Annette M.; and Reardon, James D. "Problem Oriented Records in Psychiatry." Nursing Clinics of North America 9(2)(June 1974): 289-301.

Relates the experiences of changing from source oriented to P/O charting, in three mental hospitals, in Washington State, and the difficulties and successes encountered. Relates resistances to change. Addresses issues of multi-disciplinary progress notes and treatment plans.

Gilandas, Alex John. "Implications of POR for Utilization." Review and Continuing Education." American Journal of Hospital and Community Psychiatry 25 (January 1974): 22-24.

"Because of the lack of validated treatment criteria arbitrary and rigid standards of review cannot be justified. This places limitations on the auditing process and necessitates the difficult task of maintaining flexible norms while retaining acceptable standards based on the substantiated data that do exist."

The auditing procedures expose the quality of patient management to scrutiny. The POR capitalizes on several principles of learning: Active participation, information, feedback and individuation of instruction.

Patient care improves in direct proportion to the increasing competence of the treatment team.

_____. "The Problem-Oriented Record in a Psychiatric Hospital." Hospital and Community Psychiatry 23(11) (November 1972): 336-339.

North Dakota State Hospital is one of several psychiatric institutions that are experimenting with a POR approach to record-keeping, developed by Lawrence Weed, M.D. Under the system, a patient's problems are listed, and all subsequent data, plans, and progress notes are cross indexed to the appropriate problem. Staff are enthusiastic about the system because it helps them understand the rationale behind a specific treatment and gives them a greater share in decision-making.

Grant, Richard L.; Smith, Linda; and Hawley, Christine J. "Questions Frequently Asked About the POR in Psychiatry." Hospital and Community Psychiatry 25(1)(January 1974): 17-22.

"Major differences in quality appeared in assessment subsections, where formulations by the more highly trained persons were more varied and complex. At the same time, such formulations were useful as teaching tools. Research on the effectiveness of the record should

certainly include measures of the increased competence of personnel."

"It is possible to be incorrect in the PO system as in any other record system. At the same time it is much harder to keep mistakes hidden; and much easier to notice excellence in staff performance." (Article gives examples of SOAP).

Griffith, Elizabeth W. "Nursing Process: A Patient with Respiratory Dysfunction." Nursing Clinics of North America 6(1)(March 1971): 145-154.

This discussion presented a "framework for one process of nursing and analyzed the process with reference to a patient with respiratory dysfunction"based on a psycho-social-physiologic premise.

Hersey, Nathan. "Medical Records and the Nurse." American Journal of Nursing 63 (March 1963): 96-97.

An article on the legal aspect of record keeping. The nurse is liable for making entries on nursing notes and for making use of entries made by others.

Howard, Francis, and Jessop, Penelope I. "Problem Oriented Charting: A Nursing Viewpoint." Canadian Nurse 69(8)(1973): 34-37.

Maintains charting is more meaningful when related to patient problems.

Hurst, J. Willis. "Additional Support for the Problem-Oriented System." Journal of American Medical Association 229 (29 July 1974): 562-63.

Points out difference between the POR and the PO system. POR: The vehicle one uses to accomplish an objective. Weed has said the POR will allow the assessment of patient care, education, and other factors. Four steps to it: (1) goals, (2) POR, (3) audit system, (4) correction of deficiencies every auditing. A problem found is person's modifying the Weed format with enough knowledge of the system.

To do POR, a defined data base is collected on each patient. Problem formation is dependent on data gathering! Everyone claiming to use the POR record as a system is not doing so. Some things are being left out, (use audit). Critiquing Dr. Aranita's study and article: Has learned some advantages will find more as he does work.

Hurst, J. Willis. "How to Implement the Weed System." Archives of Internal Medicine 128 (1971): 456-462.
Discusses methods of creating excellent problem lists. Discusses obstacles to implementing the Weed system. Recognizes and emphasizes that much effort and intense thought processes are the essence of medical education and the POMR.

_____. "The Problem-Oriented Record and the Measurement of Excellence." Archives of Internal Medicine 128 (1971): 818.
Excellence is providing patient care, education and individual performance can only be provided if there are standard rules for measuring. The POR is such a measuring tool.

Johnstone, E. E.; Allen, Richard H.; and Webb, Linda B. "Problem Oriented Charting: Innovations at a Psychiatric Institute." Medical Record News (October 1977): 22-35.
Describes a problem-oriented charting system designed at the Texas Research Institute of Mental Sciences (TRIMS) in Houston, Texas which includes the components essential to a medical record. This format was developed from within psychiatric practice rather than an attempt to adapt the Weed system. The redesign of the medical record is described in detail, outlining the three panel tri-folder and the graphic records and graphs. The unique charting approach has evolved since 1971.

Joint Commission on Accreditation of Hospitals."Standards for Accreditation of Hospitals." Chicago, Ill.: The Joint Commission, 1969.

Krall, Mary Louise. "Guidelines for Writing Mental Health Treatment Plans." American Journal of Nursing 76 (February 1976): 236-37.
This article points out the similarities between the requirements of a written problem plan required by some state laws for the committed patient to written treatment plans using the Problem Oriented charting format. Both must be goal directed, and most importantly, written in behavioral terminology.

MacGowan, W. A. L. "The Problem Oriented Medical Record." Irish Medical Journal 68(4) (22 February 1975): 77-80.
Explains introduction of the POMR by Weed in 1956. Reviews it in its simplest form. Includes Medical Audit.

McLean, Peter D., and Miles, James E. "Evaluation and the Problem-Oriented Record in Psychiatry." Archives of General Psychiatry 31 (November 1974): 622-625.
Explains various components of the POR in psychiatry, as well as the importance of patient follow-up. He sets down six management statements for the POR in psychiatry. The article points out some of the difficulties in adoption to psychiatry.

Malloy, Jan Lienke. "Taking Exception to Problem Oriented Nursing Care." American Journal of Nursing 76 (April 1976): 582-83.
An article that sees problem listing as misguided for nurses. The author suggests instead that the nurse focus on objectives of care stated in behavioral terms. It is stated that duplicity exists when physician and nurse both focus on the same problem list, and suggests that nurses develop their own system.

Mazur, W. P. "Problem Oriented System in Psychiatry." Psychiatric Digest 34 (June 1972): 44.
Briefly describes the POR system adapted to psychiatry.

Mitchell, Pamela H., and Atwood, Judith. "Problem Oriented Recording as a Teaching-Learning Tool." Nursing Research 24 (March-April 1975): 99-103.
A (descriptive) study done to test the assumption that students developed the ability to document more clearly, identify and plan to solve patient problems using the POMR format.

Monson, Roberta. "The POMR and the Physician." Hospitals J.A.H.A. 49 (April 1975): 51-53.
Reviews the components of the POMR. States some advantages for physicians, many of which can be applied to nurses and other health care personnel.

Morgan, Elizabeth M. "New Chart Forms Solve Old Problems." American Journal of Nursing 65 (March 1965): 93-96.
Interdisciplinary communications improved when doctors, nurses and other hospital personnel started recording notes about patient care and progress in chronological sequence on same chart form.

Muhs, Eleanor J., and Nebesky, Marjorie T. "A Psychiatric Nursing Care Plan." American Journal of Nursing 64 (April 1964): 120-22.
Presents nursing care plan form and a guide to facilitate its use.

Niland, Maureen, and Bentz, Patricia M. "A Problem-Oriented Approach to Planning Nursing Care." Nursing Clinics of North America 9(2)(June 1974): 235-45.
Addresses the POS as a facilitator of the nursing process, especially planning. Each aspect of the medical chart offers ways of establishing continuity of care through planning conferences, rounds, offers much information for planning.

Novello, Joseph R. "The POR in Psychiatry." Journal of Nervous and Mental Disease 156 (1973): 349-53.
Describes how the basic components of the PO system can be effectively adapted for use in psychiatry. Cites the successful employment of the system on a twenty-eight bed psychiatric in-patient unit employing eight elements. The advantages were enumerated.

Otway, W. "Problem Oriented Personal (POP) Medical Records for General Practice." New Zealand Medical Journal 79(510) (March 1974): 724-26.
Describes the POP Medical Record System developed by the author for use by general practitioners practicing solo or group practices. The system claims successful use at the McAuley Health Center in Auckland since 1973. The system addresses the same kinds of problems as Weed's POR. There are five steps as opposed to the four major steps in the Weed format. Color coded records are used for easier retrieval. The article was primarily for doctors, but easily expandable to nurses and other health care givers.

Rieder, A., and Wood, M. "Problem-Orientation: An Experimental Study to Test Its Heuristic Value." Nursing Research 27 (January-February 1978): 25-29.
A two-group experimental design exploring nursing staff's ability to identify underlying patient problems.

Robinson, Alice M. "Problem-Oriented Record: Uniting the Team for Total Care." R.N. (1975): 23-28.
The Medical Center Hospital of Vermont in Burlington has been using the POR system for several years now and highly recommends it. They have defined the POR, given pointers upon its implementation, assessed its value, outlined its structure, commented about some of the resistance to it and listed some criticisms of it. It has also been recommended that nurses who are interested in learning more about the POR need visit a hospital where it is being used effectively.

Scales, John, and Johnson, Michael S. "Psychiatric POMR for Use by a Multi-disciplinary Team" Hospital and Community Psychiatry 26(6) (June 1975): 371-73.
Multi-disciplinary teams introduced the POMR to Fairfield Hills Hospital in Newton, Connecticut in 1972, because of the need for revision in the record keeping system. Many of the changes were initiated on the geriatric service in order to meet Medicare standards.

Schell, Pamela L., and Campbell, Alla T. "POMR, Not Just Another Way to Chart." Nursing Outlook 20 (1972): 510-14.
Describes POMR in general and the author's use of it in a hospital setting. Describes its advantages and lists implications for nursing.

Smith, Linda C.; Hawley, Christina J.; and Grant, Richard L. "Questions Frequently Asked About the Problem Oriented Record on Psychiatry." Hospital and Community Psychiatry 25(1) (1974): 17-28.
Various questions are answered in a question/answer format about POR in a psychiatric setting. In doing so the authors inadvertently point out some benefits of the system.

Valberg, Leslie S.; Morrin, Peter A. F.; Marks, Gerald S.; Clark, Albert; and Southall, George A. "Conference on the Diagnostic and Therapeutic Aspects of Patient Care Based on Peer Review of the Problem Oriented Record." Canadian Medical Association Journal 111(7)(October 1974): 693-95.
Advocates conferences to consider diagnostic aspects of medical care. Overlaps to detail approaches to the problems of the whole patient. Explains organization of conferences timing, participants, procedure. Seems to have had widespread effects on all health personnel.

Valentine, John. "Peer Review, Quality of Care, and Problem-Oriented Records: Three Aspects of Accountability." Hospital and Community Psychiatry 25(10) (October 1974): 678-79.
Brief article addressing title well.

Weed, Lawrence. "Medical Records That Guide and Teach." New England Journal of Medicine 278 (14 March 1968): 593-600; (21 March 1968): 652-57.
Addresses skillful management of multiple problems, management of psychiatric, demographic problems and problems out of context. New management by POMR format ties it all together.

Williams, Donald H.; Jacobs, Selby; Debski, Albert; Revere, Madeline. "Introducing the POR on a Psychiatric Inpatient Unit." Hospital and Community Psychiatry 25 (January 1974): 25-28.

"The narrative chart was inadequate as an administrative and legal document because residents considered such records a threat to patient confidentiality and a chore unrelated to good patient care or to their own learning."

Some residents and staff were greatly concerned about protecting patient confidentiality and deliberately recorded little information. With the increased emphasis on the written record, some staff members feared their deficiencies in writing skills would be revealed resulting in a loss of respect from their co-workers.

In general, the staff with the most clinical experience or formal education had fewer initial difficulties with the new charting than staff members with less clinical skills or formal education. (This article also includes advantages of the PO System.)

Woody, Mary, and Mallison, Mary. "The P.O. System for Patient Centered Care." American Journal of Nursing 73(7)(1973): 1168-1175.

Describes system of POR and their use for conditioning.

Yarnall, Stephen R., and Atwood, Judith. "Problem Oriented Practice for Nurses and Physicians: General Concepts." Nursing Clinics of North America 9(2)(June 1974): 215-28.

Gives rationale for the POR system. Stresses the justification of outcome by stating and describing the seven "c's". Reviews the components of the POR system. Gives hints for implementation. Draws conclusions from the information.

Other

Weed, L. L. "POMR." 56 min. audiotape available from MCSA, 1107 N.E. 45th St., Seattle, Washington 98105.

APPENDIX B

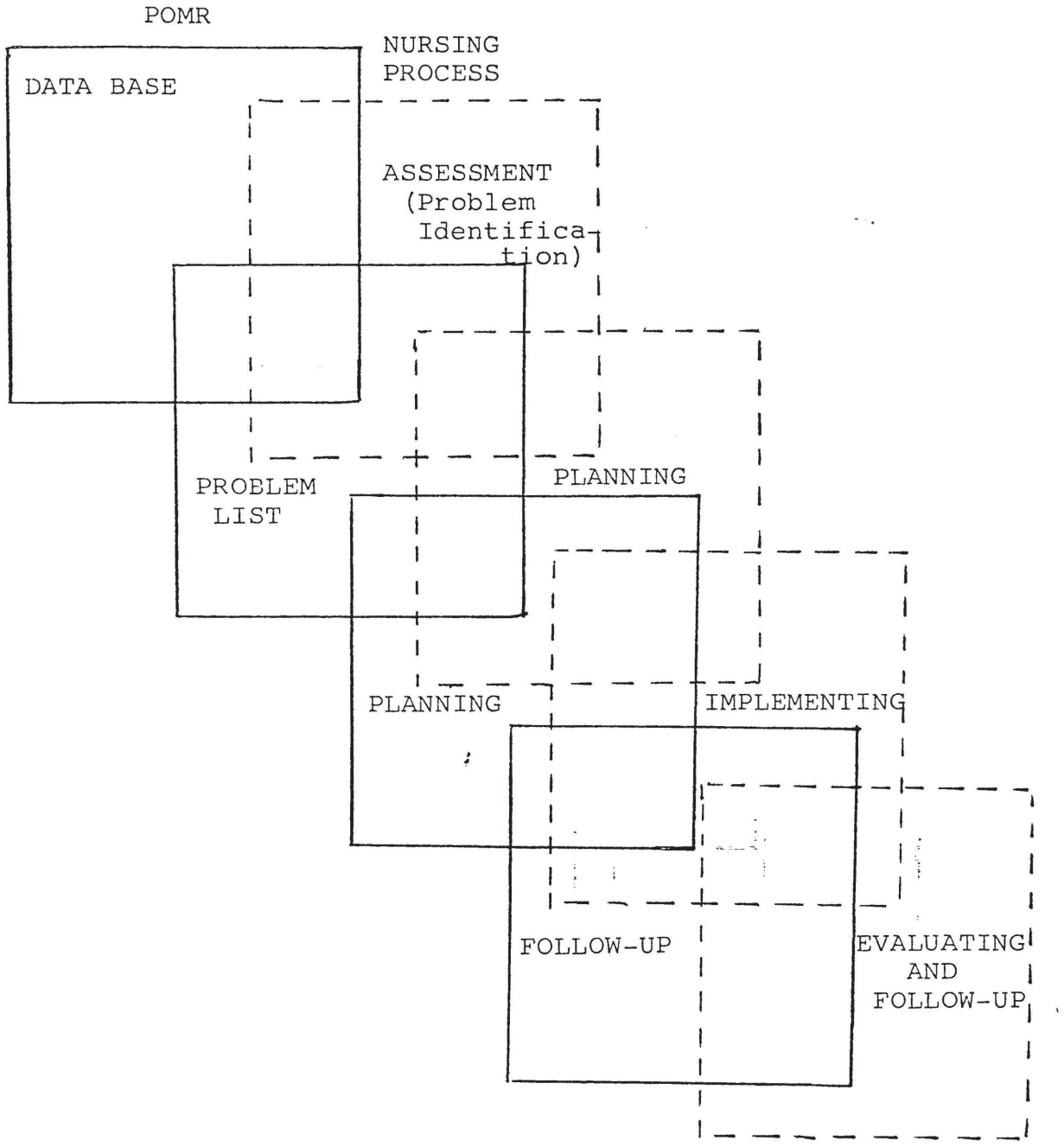

Fig. 1. Correlation of POMR to Nursing Process

APPENDIX C

MEDICAL RECORDS STANDARDS

Joint Commission on Accreditation of Hospitals

Standard I: An adequate medical record shall be maintained for every person admitted as an in-patient, out-patient, emergency patient. The purposes of the medical record are:

To serve as a basis for planning and for continuity of patient care;

To provide a means of communication among the physician and any professionals contributing to the patient's care;

To furnish documentary evidence of the course of the patient's illness and treatment during each hospital stay;

To serve as a basis for review study, and evaluation of the care rendered to the patient;

To assist in protecting the legal interests of the patient, hospital, and responsible practitioners, and;

To provide data for use in research and education.

APPENDIX D
Privileged Communication

RESEARCH SERVICE
RANS ADMINISTRATION HOSPITAL
HOUSTON, TEXAS 77031

For Research Office Use
R&E COMMITTEE ACTION — PROJECT NUMBER:

DATE: — DATE PROJECT ACTIVATED:

SPECTUS OF RESEARCH PROJECT

TITLE OF RESEARCH STUDY

	MRIS NO.	NAME	DEGREE	ACADEMIC APPT.
PRINCIPAL INVESTIGATOR		ANN E. FRANK	BSN	
CO-INVESTIGATOR(S)		NONE		

TYPE OF SUPPORT (check one)

VA RESEARCH FUNDS (NEW)	___	EXTRA VA (GRANT) REQUEST	
VA RESEARCH FUNDS (RENEWAL)	___	COMMON RESOURCE SUPPORT ONLY	
VA CO-OP STUDY	X	NO SUPPORT REQUIRED	
VA CAREER DEVELOPMENT			

5A. DURATION OF PROPOSED STUDY	5B. FUNDING 1ST FISCAL YEAR	5C. TOTAL FUNDING ALL YEARS
FROM: 3-1-78 TO: 4-1-78	NONE	NONE

TABLE OF CONTENTS (Fill in page number of all applicable sections)

	PAGE NO.		PAGE NO.
COVER PAGE		HUMAN STUDIES	
SECTION I		ANIMAL USE	
SECTION II	13	RADIOISOTOPE	
SECTION III		INVESTIGATIONAL DRUGS	
		EDUCATION	

7. PRINCIPAL INVESTIGATOR'S SALARY STATUS IN RELATION TO APPOINTMENT AT VA HOSPITAL (check one)

FULL-TIME VA	___	PART-TIME VA	
CONSULTANT	___	ATTENDING	
WOC	___	NONE	

8A. NAME & ADDRESS OF ACADEMIC INSTITUTION AT WHICH PRINCIPAL INVESTIGATOR HAS FACULTY APPOINTMENT

9. TITLE OF MAJOR VA APPOINTMENT

R.N. NURSING SERVICE

8B. TITLE OF MAJOR ACADEMIC APPT.

10. VA SERVICE IN WHICH THIS APPOINTMENT IS HELD:

NURSING

8C. DEPT. IN WHICH THIS APPOINTMENT IS HELD:

NURSING

PRINCIPAL INVESTIGATOR SIGNATURE Ann E. Frank DATE 11/15/78

CHIEF OF SERVICE SIGNATURE Elizabeth Hood DATE 11/21/78

10-1136(580)
1972

APPENDIX E

CHARTING AUDIT

	Yes	No	NA
1. Was an admission note done on the patient?			
2. Did it identify the following: a. Chief complaint.			
b. Duration of problem.			
c. Observation of patient's physical condition.			
e. Allergies.			
f. Medications presently taking.			
g. Prosthesis.			
3. Was the following recorded accurately? S:			
O:			
A: based on S & O			
P: the nurses' plan			
4. Was the care plan developed from the data and assessment?			
5. Was it implemented?			
6. Were nursing directives on the plan for the problems identified?			
7. Did the directives include: a. Need for further data collection.			
b. Nursing instructions.			
c. Education.			
8. Was there evidence of revision in the patient plan of care?			
9. Was there any indication in the progress notes that the nursing plan of care was followed?			
10. Do the progress notes reflect the patient's condition and progress?			
11. Are flow sheets, graphic sheets and medication sheets being used properly?			
12. Did the discharge note include what information the patient was given about each problem?			
13. Were referral services used if indicated?			

APPENDIX F

CHARTING AUDIT CRITERIA (MODIFIED)

	Yes	No
1. Was an admission note done on the patient?		
2. Did the admission note identify the following:		
a. Problem		
b. Duration of problem		
c. Observation of patient's physical condition		
d. Mental/emotional status		
e. Allergies		
f. Medications presently taking		
g. Prosthesis(es)		
h. Suicidal assessment		
i. Family information/involvement		
j. Mention or disposition of valuables		
3. Were the following recorded accurately?		
a. Patient's thinking, statements or (his) observations		
b. Nursing perceptions of problem(s)/ objective findings		
c. Nursing assessment		
d. Nursing plan		
e. Were plans made relevant to S & O data and assessment?		
4. Were nursing directives on the plan for the problems identified?		
5. Did the directives include:		
a. Need for further data collection?		
b. Nursing instructions?		
c. Education?		
d. Action oriented intervention or statement of inaction?		
6. Was the plan implemented?		
7. Was it documented in the progress notes that the nursing plan of care was followed?		
8. Were the results noted?		
9. Was there evidence of revision or up-dating of the nursing care plan?		
10. Do progress notes reflect the patient's current condition and progress?		
11. Were referral services used if indicated?		
12. Was there a discharge planning note?		
13. Did the discharge note include:		
a. Information/instruction the patient and his family were given about each problem?		
b. Plans, post-hospitalization?		

APPENDIX G

CRITERIA FOR CHART SELECTIONS BY NURSE RESEARCHERS

1. Patients who are actively engaged in the in-patient drug treatment program.

2. Patients whose treatment is expected to last a minimum of four weeks.

3. Patients who are mentally and physically able to answer treatment planning questions.

4. Patients with a current treatment record, and an old record prior to 1974 when the POMR system was officially started. (An alternate record of pre-treatment planning.)

5. Select six charts. (Each current chart will have an old comparative record which will total twelve charts on six patients.)

6. The patient must have completed his initial week of orientation.

7. The patient must have met with the Treatment Planning team.

8. Use Modified Chart Criteria form to monitor charts.

APPENDIX H

CHARTING AUDIT CRITERIA CATEGORIZED AND NUMBERED

ADMISSION ASSESSMENT

1. Was an admission note done on the patient?
2. Did the admission note identify the following: Problem?
3. Duration of the problem?
4. Observation of patient's physical condition?
5. Observation of mental/emotional status?
6. Allergies?
7. Medications presently taking?
8. Prosthesis(es)?
9. Suicidal Assessment?
10. Family information/involvement?
11. Mention or disposition of valuables?
12. Were the patient's thinking, statements or his observations recorded?
13. Nurses objective perception of problems recorded?
14. Was a nursing assessment of problems done?

PLANS AND/OR DIRECTIVES

15. Was a nursing plan stated?
16. Were the stated plans relevant to subjective/objective data?
17. Were nursing directives for the plan identified?
18. Did the directives include the need for further data collection?
19. Did the data include nursing instructions?
20. Patient education?
21. Intervention or statement of inaction?
22. Was the plan implemented?

PLANNING AND DOCUMENTATION

23. Was the nursing plan of care followed?
24. Were the results noted?
25. Was there revision or updating of the plan?

DOCUMENTATION

26. Was the patient's current condition reported?
27. Were referral services used?
28. Was there a discharge planning note?
29. Did the discharge note include instructions and/or information given to patient or family?
30. Did the discharge note include plans after hospitalization?

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