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A study of home health care nurses' client visit documentation

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A STUDY OF HOME HEALTH CARE NURSES' CLIENT VISIT DOCUMENTATION

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ABSTRACT

A STUDY OF HOME HEALTH CARE NURSES' CLIENT VISIT DOCUMENTATION

by Margaret Wollen-Olson

The purpose of this field research was to investigate the quality of the documentation of client visits by home health care nurses. The setting was three Medicare certified home health agencies and the homes of 22 clients; the sample was seven nurses. A tool was developed for the recording of the nurses' intervention activities and their clients' responses observed during the home visits. A comparative data analysis tool was developed to analyze the nurses' visit documentation notes and score them for comprehensiveness, accuracy, and systematic organization.

Scores were obtained for individual visit notes and for each nurse's overall documentation of multiple visits. Individually, the visit notes documentation scored best in systematic organization and poorest in comprehensiveness of documenting client/caregiver responses. The two nurses who achieved the best overall documentation scores had one common demographic factor: the previous experience of performing systematic chart audits for billing and quality assurance purposes.

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better in spite of my once having promised not to
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Chapter 1

INTRODUCTION

The general purpose of this research was to investigate two main questions: (a) What constitutes appropriate documentation of a home health visit? and (b) How do home health nurses manage this task? This study was pursued in order to examine the requirements for documentation of home health care visits and to identify variables or conditions which influence this process.

Cost containment efforts in today's health care industry are based on the increased regulation of who qualifies for which health care services, for how long, and under what conditions. Regulations are determined by the government or private agencies which govern and finance the health care services. Agencies focus their efforts on the careful monitoring and evaluation of the providers and their client population. The degree of compliance with the regulations by the providers and evidence of client eligibility determine the insurance carrier's fiscal responsibility for reimbursement for the services provided. As a result, providers must adopt fiscal accountability as a major determinant of their practice in providing health care services.

At the same time that health care service providers face increased fiscal restrictions, they also must contend

with demands to maintain and improve the quality of the health care provided. Consumer protection agencies, as well as state and federal regulatory and licensing agencies, also monitor and evaluate all aspects of health care. These agencies focus on a facility's compliance with standards of practice for safety and effectiveness of care as well as health care professionals' compliance with their own standards of practice. Often, this monitoring is done through structured quality control and quality assurance (QA) programs which externally impose professional and legal accountability on the practice of the health care providers.

The health care services provider is caught in the middle between the fiscal accountability required by government and private insurances to maintain reimbursement, and the legal and professional accountability required by quality advocates to meet rising expectations for standards of care. Whether an individual or an entire facility, the provider is constantly struggling to give professional care to meet patients' needs in spite of constraints imposed from all sides.

Home health care agencies are a rapidly growing segment of the health care industry which is affected daily by these regulatory efforts. Historically, home health care agencies relied on varied funding sources: (a) private contributions from church and fraternal organizations, (b) allocations

from United Way and local health and welfare departments, and (c) fees (Trager, 1986). Through the Social Security Act of 1966, Titles XVIII and XIX established Medicare at the national level and Medicaid at the state level (Jacob, 1985), the latter renamed by California as "MediCal." The home health care benefits provided through these medical insurance programs quickly became the principal funding source for home health care agencies serving the elderly and categorically needy.

The increased use of home health care benefits has been precipitated by the cost containment system of prospective reimbursement to hospitals. Patients now experience shorter hospital stays and must receive additional medical treatment in the home. Medicare's federally mandated system of prospective reimbursement through Diagnosis Related Groups, or "DRGs", was implemented in the mid-1980s. This action has been quickly followed by the adoption of similar systems by private insurance companies and health maintenance organizations. In both the public and private sectors, managing patients in a non-hospital setting has become an increasingly viable and effective way of reducing hospital and overall health care costs.

The increased utilization of home health benefits for the care of the growing elderly population has been paralleled by the rapid growth in the numbers of Medicare

certified home health care agencies. In 1980, there were 2,859 Medicare certified agencies in the United States; by November of 1984, there were 5,503 such agencies (Jacob, 1985). Stanhope and Lancaster (1984) report that home health care literature at that time quickly focused providers' attention on the issue that growing numbers of agencies brought increased competition and more awareness of the dual bind. "To survive in this competitive arena, one must continue to provide quality care and also be cost effective without compromising accountability" (Stanhope & Lancaster, 1984, p. 784).

Despite the reduced costs of medical care to the elderly in their homes, the federal government's Health Care Financing Administration (HCFA) demands that home health care agencies continually demonstrate their compliance with Medicare home health care regulations and justify their expenditures through extensive record keeping. Failure to comply with such documentation procedures leads to denial of reimbursement for services, often long after the services have been rendered (Omdahl, 1988).

For the agencies regulating safety and standards of health care and practice, documentation also serves as a means for identifying and measuring the quality of health care. Health care professionals may be providing thorough and high quality health care services. However, if their

work is not documented, or not documented well, the quality may not be evident to others. The tendency is to believe that if something "isn't documented, it probably didn't happen" (Stanhope & Lancaster, 1984, p. 798).

Problem

A review of the medical records of a patient's chart, or a chart audit, has become a powerful tool of state and federal regulatory agencies to determine compliance with regulations and standards. As it exists, the medical record is presumed to be accurate, complete, and correct (Gross, 1989). An audit of that record is widely accepted as a valid tool to determine quality of client care. The nationally accepted Joint Commission for Accreditation of Health Care Organizations (JCAHO) routinely uses chart audits in acute care facilities as a method for evaluating the health care services provided. For example, the quality of nursing care is evaluated through an appraisal of the nursing process as it is reflected through the documentation in the patient's chart (JCAHO, 1990).

This reliance on the chart audit continues despite findings which question this practice. Maciorowski, Larson, and Keane (1985) developed and tested a tool to assess the reports of quality assurance studies which focused mainly on acute care settings. The researchers found that retrospective QA studies based on hospital chart reviews are

often not accurate evaluations of the quality of care delivered; rather, "they are evaluations of the quality of documentation of that care" (p. 41). They surmised that these two aspects of practice--quality of care and documentation--may not be correlated. In 1981, Koerner studied selected correlates of job performance of community health nurses. Tentative findings in this study also did not support the common assumption that the record audit is a valid method of measuring the quality of care delivered by the nurse. In one specialty area of community health nursing practice, home health nurses continuously perform care autonomously in the patient's home. Concurrent monitoring of the care remains difficult to achieve, and the retrospective chart audit still predominates as the method of evaluating the quality of services provided.

HCFA's most recent efforts to reduce the federal deficit by limiting spending in outpatient settings directly targeted documentation as the primary means of evaluating services (Shamansky, 1988). In 1985, HCFA introduced new forms for planning and summarizing health care services provided. This change dictated a new organization of information that also substantially increased the volume of required paperwork. Additionally, this change was viewed by home health providers as a preliminary step in improving screening mechanisms. This screening continues to be used

to quickly identify non-compliance with HCFA regulations and to facilitate the denial of reimbursement for services. In reality, the examination of records by Medicare fiscal intermediaries has substantially increased denials across the country and has threatened the survival of many home health care agencies. A recent national study of Medicare certified home health agencies revealed that 67% of the 5,300 surviving agencies have suffered an increase in the number of claims denied reimbursement (Morrissey-Ross, 1988).

Home health care nurses are individually accountable for fiscal regulations as well as for professional practice standards in a specialized and rapidly changing area of health care services. They must be clinical experts not only in the nursing care they give, but also in their documentation skills and strategies. A major portion of these skills and strategies is demonstrated daily when writing the visit notes for clients seen each day.

Purpose and Need for Research

The purpose of this exploratory field research was to investigate the quality of the documentation of visits done by home health care nurses. Because the content of such visit notes is closely scrutinized during a chart audit, quality is crucial to the success of an audit which monitors

for compliance with professional care standards and for reimbursement purposes.

For the client outcomes of home health care nursing to be directly attributable to nursing care, the nursing interventions themselves must be documented in sufficient scope, depth, and detail to adequately depict the activities performed throughout the application of the nursing process. Documentation is then ultimately a matter of accountability for the professional nurse. This accountability in the written record is important in two ways: (a) It proves the necessity and reasonableness of services to the third party payor for reimbursement, and (b) it substantiates to the nursing profession itself the value of nursing care as distinct in theory and practice.

The skill with which a home health care nurse performs this task of documentation is a critical performance issue in the evaluation of the professional abilities of a nurse practicing in this distinct specialty area. There is little significant information in the research literature concerning home health nurses' abilities and current practices in performing this task of visit documentation.

Research Questions

This study was done to investigate the following general research questions:

1. What constitutes appropriate documentation of a home health visit?

2. To what extent does the documentation of a visit by a home health care nurse reflect the nursing services rendered and client outcomes observed during a home visit?

For the purposes of this research study, these general research questions were further delineated by the following questions:

1. What characteristics must be evident for the visit note to (a) document adequately for reimbursement purposes, and (b) document adequately for purposes of compliance with professional standards?

2. How do home health nurses manage this task of documenting each client visit?

3. What variables or conditions are identified as influencing this process and to what extent?

Operational Definition of Terms

For the purpose of this study, the following definitions were used:

1. Caregivers include the family, friends, or significant others who assist the home health client with health care and activities of daily living.

2. Case Manager is the home health care nurse assigned to an individual client who is responsible for managing and

coordinating the care and services of a multidisciplinary team.

3. Chart Audit is a method of reviewing the medical record of health care services provided for purposes of determining compliance with regulatory standards for reimbursement and quality of care.

4. Client Outcome includes the changes occurring in the client's health and functional status as a result of the home health care services provided.

5. Client Visit is a planned home visit made by a home health care nurse to render nursing services to a client residing at home.

6. Client Visit Notes are the recordings of the home visit by the home health care nurse for purposes of documenting the nursing services provided and the resultant client responses and outcomes in the client's medical record.

7. Home Health Care Agency is a Medicare certified facility providing intermittent, skilled nursing care (and usually additional services of medical-social work, physical therapy, occupational therapy, and speech therapy) to clients in their homes. All services rendered are under the care and supervision of a physician.

8. Home Health Care Nurse is a professional registered nurse working in a Medicare certified home health care facility.

9. Nursing Interventions are the actions taken by the nurse to carry out the written Plan of Care.

10. Plan of Care is the written interdisciplinary plan for the treatment of the client receiving home health care services.

Research Methods

Research Design

This study was descriptive and used field research techniques. Both qualitative and quantitative data were collected for a content analysis.

Setting

The setting for this study was located in two distinct areas. Observational data were collected by the researcher in the private homes of 22 clients in Santa Clara County. Medical record data were obtained by auditing client charts in three Medicare certified home health care agencies in Santa Clara County.

Sample

This study used a convenience sample from three home health care agencies. The sample consisted of seven registered nurses who were currently acting, or had experience, as case managers of client care. Twenty-two

client visit notes which were written by these nurses were examined.

Procedure

Approval of the project proposal was granted from the San Jose State University Human Subjects Institutional Review Board on October 3, 1988 (Appendix A). The nursing supervisors of six home health care agencies in the South Bay and Mid-Peninsula areas were contacted by telephone to request permission to make a personal visit to the agency to explain the research and obtain agency consent. Four supervisors were visited personally; written consent to approach agency nurses was obtained from three supervisors (Appendix B).

The written consents by the three supervisors included permission to: (a) include agency staff nurses in the sample, (b) allow the researcher to be a non-participating observer of home health care staff nurses making client visits, and (c) allow the researcher to subsequently obtain copies of the nurses' documentation of each visit for review and analysis.

Written consent to participate (Appendix C), as well as demographic data (Appendix D), were obtained from each nurse in the sample prior to being observed. For each client visited by the nurse being observed, written documentation of the client's verbal consent (Appendix E) for the visit as

well as the client's case history data (Appendix F) were also obtained prior to the visit.

The researcher developed an observation tool (Appendix G) to facilitate accurately recording the activities of the nurse and client during the home visit. An analysis tool (Appendix H) was developed to compare the observation notes by the researcher with the visit notes written by the nurse. Observations were made over a period of 2 months. Each nurse was observed during two to four visits for a total of 22 visit observations.

Analysis of Data

To achieve the content analysis, the researcher compared the nurses' visit notes with the recorded observation notes. Criteria were developed for determining frequency and percentage scores in the descriptive analysis of the documentation. The scores were also compared to the nurses' demographic data for identification of factors which might be significant for further study.

Scope and Limitations of Study

This field research was strictly exploratory in nature. The convenience sample was small in size, limited to a particular geographic area, and limited in focus. The study was a preliminary investigation of how visit documentation is done by home health care staff nurses during a time when they must routinely meet well defined standards on a daily

basis. It was intended to identify possible variables for use in future, more quasi-experimental studies. It was intended to give some insight into the concept of chart audits as a means to measure the quality of care provided. The results were not meant to have statistical significance, but rather to serve as pilot research, stimulating questions, and spurring further research in the specialty practice of home health care nursing. The tools for this study were developed to observe and analyze nurses' visits and their documentation. With further development, these tools could be used for assessing home health care nurses' learning needs and evaluating their performance.

Chapter 2

CONCEPTUAL FRAMEWORK AND REVIEW OF RELATED LITERATURE

Conceptual Framework

In the practice of professional nursing, documentation is a skill which is learned in order to report and record the process and activities of providing nursing care. The process and activities of providing nursing care are also learned problem-solving practices which are termed the "nursing process." If the documentation is an accurate representation of what occurs in providing nursing services, then the nurse is performing as a thinking adult. In demonstrating the complex critical thinking and problem solving of the nursing process, the nurse is showing the outcomes of education in that process rather than the results of mere training for a task. In general, nurses must continually be educated to the constantly changing skills and knowledge required for the competent and safe practice of their profession.

A conceptual framework is useful to determine adequate learning outcomes as well as to provide a model to demonstrate and explain interrelationships of components involved. If the nurse's documentation is deficient and not an accurate representation of occurrences, this deficiency is most likely a result of inadequate education. Therefore, a conceptual framework especially appropriate for this study

is Malcolm Knowles' Theory of Adult Learning (Knowles, 1970). This theory is applied to the practice of educating adults.

This theory includes a set of generalizations regarding adults and their accommodation in the educational process. These generalizations are not contrary to those of the pedagogical model regarding the education of children, but are now widely accepted and utilized as parallel assumptions and strategies for the process of the education of adults (Darkenwald & Merriam, 1982).

Darkenwald and Merriam (1982) describe the broad conception of education as the systematic, deliberate, and sustained effort to transmit, evoke, or acquire knowledge, attitudes, values, or skills, as well as any outcomes of that effort (p. 3). Thus defined, the education of adults and children occurs today and has always occurred in many settings and through many kinds of activities. This broad view of learning is widely accepted by scholars and planners who promote the concept of lifelong learning. These advocates assert that education is a process that continues in one form or another throughout life, and that the purposes and forms of education must be adapted to the needs of individuals at different stages in their development. Education is seen as an integral part of living, and all the institutions of society are considered resources for

learning. Pointedly, the conditions inherent in the science-based, post-industrial technological age since World War II include rapid change, the "knowledge explosion," and increasingly complex social forces. These conditions are making the concept of lifelong learning a constant reality (Darkenwald & Merriam, 1982).

Lifelong learning implies the need for society to make adequate provisions to meet the educational needs of adults who have left formal schooling. Additionally, there is the implication of the need to better prepare young people to continue their education as self-directed and competent adult learners, which means emphasis on learning-how-to-learn (Brockett, 1987).

To arrive at a definition of adult education, Darkenwald and Merriam (1982) first distinguish between education and learning. Education has the element of being organized and of consequential duration, aspects of which are not necessarily a part of learning, which can be incidental, unsystematic, and of short duration. Additionally, all education involves learning, although all learning does not involve education.

For purposes of examining the term adult education, adult is best described as someone who has left the role of full-time student, which is the principal social role of childhood and adolescence. The adult has assumed the role

of worker, spouse, and/or parent, and is primarily engaged in the "ordinary business of life" with the role of student in a subordinate position (Darkenwald & Merriam, 1982, p. 8). With these components described, adult education is thus defined as the "process whereby persons whose major social roles are characteristic of adult status undertake systematic and sustained learning activities for the purpose of bringing about changes in knowledge, skills, attitudes, or values" (Darkenwald & Merriam, 1982, p. 9).

Knowles (1984) related that until the early 1940s, the literature on teaching adults was merely anecdotal, providing principles or guidelines at most. In the early 1960s, Knowles began developing a theoretical framework and adopted a term which had been coined in Europe. This term was androgogy. Androgogy provided a label for the growing body of knowledge and technology with regard to adult learning and was defined as "the art and science of helping adults learn" (p. 6).

Between 1960 and 1980, research studies provided increased knowledge about the unique characteristics of adults and their learning processes. After the development of a substantial body of knowledge, Knowles (1984) developed this knowledge into a systematic framework of assumptions, principles, and strategies. Knowles first published the results of his work in 1970 with the book, The Modern

Practice of Adult Education: Andragogy Versus Pedagogy. The subtitle was later changed in 1980 to From Pedagogy to Andragogy.

Knowles' Andragogy in Action (1984) explained his theory via the andragogical model which has since been widely used in a variety of programs and facilities. Inherent in the model are five crucial assumptions about the characteristics of adult learners: (a) adult learners are self-directing; (b) adult learners come with a quantity and variety of life experiences; (c) adult learners are ready to learn when they experience a need to know or do something in order to perform more effectively in some aspect of their life; (d) adult learners enter an educational activity with a life-centered, task-centered, or problem-centered orientation to learning which indicates learning must be obviously relevant to the learner's life tasks; and (e) for adult learners, external motivators do exist, but the most potent motivators are internal ones like self-esteem, recognition, improved quality of life, or self-actualization (p. 12).

From these assumptions, Knowles (1970) established that there are certain conditions of learning that are more conducive to adults' growth and development than others. These he terms "superior conditions of learning" which are produced by practices in the learning-teaching transactions

that adhere to concomitant "superior principles of teaching." These superior conditions of learning are identified as the following:

1. The learners feel a need to learn.

2. The learning environment is characterized by physical comfort, mutual trust and respect, mutual helpfulness, freedom of expression, and acceptance of differences.

3. The learners perceive the goals of a learning experience to be their goals.

4. The learners accept a share of the responsibility for planning and operating a learning experience, and therefore have a feeling of commitment toward it.

5. The learners participate actively in the learning process.

6. The learning process is related to and makes use of the experiences of the learners.

7. The learners have a sense of progress toward their goals (p. 53) (Appendix H for complete chart).

The implications for use of these assumptions is apparent in the continuing educational processes which must take place in the nursing profession. Staff development and training are required on a continual basis to educate nurses to the constant changes in knowledge and technology in the nursing profession and in allied health care fields. These

educational needs apply to the general knowledge and skills common to all nurses as well as to the more distinctive knowledge and skills required in specialized clinical areas. Home health care nursing practice is a clinical specialty area that works closely with many allied health care professions.

Review of the Literature

This review of the literature on the documentation of home health care visits begins with research on nursing educational preparation for practice in the community setting and research on the issue of nursing documentation in general. It also includes research on the practice of community health nursing and includes reports on research specific to home health care nursing and documentation issues. Information on home health care nursing documentation consists mostly of studies about documentation for reimbursement. These studies are mainly concerned with the written plan of care for services. There also is substantial research on guidelines for documentation techniques based on retrospective chart audits. However, the lack of findings about concurrent reviews of visit documentation makes the need for this field research study obvious.

Nursing Educational Preparation for Practice

The long-standing discussion over nursing educational preparation for practice focuses on the differences in the ways in which nurses function, depending on their level of educational preparation. Kramer (1981) declared that "the goal of baccalaureate nursing education is to prepare a liberally educated person to function as a professional nurse in a variety of nurse roles and health care settings" (p. 224). Kramer defined five specific roles or functions of a nurse as: (a) direct caregiving, the mainstay of hospital nursing; (b) beginning managerial-leadership functioning; (c) health promotion and health supervision; (d) teaching or counseling; and (e) health and illness screening.

Of these, Kramer (1981) stated that the associate degree nurse (ADN) or technical nurse is prepared mainly to function in the caregiver role in the hospital. The education of the baccalaureate degree nurse (BSN) includes liberal arts. A liberal arts education acts as a catalyst for enrichment of the self and is the type of learning which permits and stimulates constant growth as a person (p. 224). BSN programs also contain relatively more emphasis on the assessment and evaluation parts of the nursing process. Assessment and evaluation tasks are found in the higher domains of the learning strata. In nursing, these abilities

are needed to deal with complex identification and interpretation of underlying health and illness states.

An early exploratory study in 1972 by Waters, Vivier, Chater, Urrea, and Wilson described differences between technical and professional nurses in the practice of nursing in clinical settings. Differences were identified in the areas of problem solving and decision making as well as scope of practice and attitudes toward practice. BSN prepared nurses were reported to be more self-directing and creative.

A 1977 study by Gray, Murray, Roy, and Sawyer of graduating nursing students in both ADN and BSN programs reported definite differences in the manner in which nursing was practiced. The technical nurses performed functions expected of all nurses in the form of technical tasks. The BSN prepared nurses used a broader knowledge base and more complex problem solving and analytical functions in operationalizing the nursing process. Another study by Frederickson and Mayer (1977) used a standardized test for critical thinking in problem solving. They found that the BSN nurses scored significantly higher than ADN or diploma nurses.

When nursing is practiced outside the acute hospital in the broader scope of community health nursing, differences in functioning are seen as even more important in effecting

appropriate patient care outcomes. Vincent and Davis (1988) studied public health nurses dealing with social problems in a Visiting Nurse Association (VNA) setting. Visiting Nurse Associations are distinctly a home health care type of nursing service in the community. Vincent and Davis (1987) found that the identification of, and response to, clients' social problems differed according to the education of the nurse, even when the nurses had similar years of community health nursing experience. These results support the idea that BSN prepared nurses are more self-directed in thinking and problem solving processes than ADN or diploma nurses.

The discussion of this study, as well as the discussion by Hanner (1985), endorses a position that requires public health nurses to have a broad educational background, i.e., the liberal arts education referred to earlier by Kramer (1981). This broader education develops the independent judgment and critical thinking required for the nurse to function more independently and with full responsibility for performing all of the functional roles of the professional nurse in the community health setting.

Nursing Documentation

Nursing documentation is discussed in the literature usually as a means to study either nursing quality assurance or job performance. Koerner's 1980 study used a documentation audit tool to identify variables that

influence job performance in a community health setting. This tool was developed to study the records of nurses' documentation as a means to assess the nursing care given to clients. Koerner (1980) explained that response variations might be due to differences between nurses in charting their care. These differences could be influenced by available time, ability to write clearly, or workload. Koerner concludes that "thus, record audits may not clearly reflect the quality of care actually given by the nurse" (p. 48).

Phaneuf and Wandelt (1981) explored a method of nursing evaluation which was process oriented. The method was an effort to obtain reliable data to evaluate quality of nursing care in addition to documenting the quality and quantity of essential nursing care. Initially, this research was done in an effort to commend good nursing care and identify poor care. Using a combination of tools developed in the 1960s, Phaneuf and Waldelt attempted to develop a method of providing criterion-referenced measurements of quality assurance in nursing care in a hospital setting which would yield reliable and valid quantitative data. The various tools were combined in this evaluation method because the authors recognized that the Phaneuf tool alone, designed for evaluating nursing care retrospectively through examination of patient care records, was considered insufficient.

The Phaneuf tool was combined with the Quality Patient Care Scale (Qualpacs-1965) and the Slater Nursing Competencies Rating Scale (Slater Scale-1968). Both of these scales focus on identifying quality of nursing care by direct observation of nursing actions in an acute care setting. The authors declared that for quality assurance reliability, there must be a combination of direct observations as well as record audits. This combination would: (a) correctly distinguish what occurs during nurse-patient interactions, and (b) assess the quality of what is documented about the nurse-patient interactions in the acute care setting.

In the community health setting, Hand, Bruno, Pfeffer, and Plath (1981) reported that the Department of Public Health in Missoula, Montana, revised the Phaneuf audit tool to better emphasize both the nursing care and documentation specific to home health care nursing practice. Based on requirements for quality assurance focused on retrospective chart review, they reported the development and testing of the chart audit tool for validity and reliability. The researchers did not report, however, any provisions for basing quality assurance audits in home health care on the direct observation of the client care services provided.

Maciorowski, Larson, and Keene (1985) reported similar findings on the documentation of quality assurance studies

in the hospital. These researchers cited the 1989 guidelines of the Joint Commission on Accreditation of Hospitals which dictated the need for nursing to be accountable for the care rendered by its practitioners as demonstrated through an organized quality assurance program. Their discussion of the tool developed to evaluate quality assurance studies states clearly that "retrospective QA studies based on chart review are not evaluations of the quality of care delivered; they are evaluations of the quality of documentation of that care" (p. 41). They suggest "These two aspects of nursing practice--quality of care and documentation--may not be correlated.... Nevertheless, one who thinks clearly must be able to write clearly. If QA programs are to be of continued value, they must be documented carefully, systematically, and completely" (p. 42).

The concept of correlating thinking and writing abilities is common in the literature about English composition. Pinkstaff (1985) was concerned with the relationship between thinking and writing and described an experience in journal writing by BSN students in a public health practicum. Her discussion of related theory cited research on the relationship between thought, speech, and writing. This research led to the concern for improving writing skills in order to improve other student

competencies. Pinkstaff (1985) continued that "writing leads to further thinking, clarification, and generalizing" (p. 25), and subsequently, learning to write better. Additionally, she noted that "writing requires (cognitive) connections not only to be made but to be declared, thus involving the student actively in learning" (p. 25). For BSN students preparing for professional nursing role functions, Pinkstaff found this project emphasizing writing and thinking skills to be effective in improving students' performance in multiple communication modes. Borrowing from English composition techniques, Pinkstaff (1985) concluded that these nursing students found that having to clarify ideas and concepts in writing made these ideas and concepts clearer in the students' minds.

Criteria for documentation in community health nursing were first addressed distinctly in the American Nurses Association's (ANA) Standards of Community Health Nursing Practice, 1976 edition. Standards IV and X state that data collection should be systematic, continuous, accessible, and recorded (Appendix I). Revised in 1986, each of the standards addressed not only how the nurse functions in performing the nursing process, but also that the documentation is done in an accurate, systematic, comprehensive, and retrievable manner. Based on these documentation criteria, Rudolph, Kaiser, and Corrigan (1986)

tested the construct validity of a clinical performance evaluation tool on baccalaureate nursing students in two community health practicums. Their criteria for performance of documentation skills evaluated how well the students recorded data in terms of specificity, objectivity, completeness, conciseness, and organization in a retrievable format. The documentation evaluation was done via retrospective chart audits.

Based on the community health nursing standards, ANA also developed Standards of Home Health Nursing Practice in 1986 (Appendix J). Documentation requirements are mentioned throughout. Standard III. Data Collection states that "the nurse continuously collects and records data that are comprehensive, accurate, and systematic" (p. 7). The criteria for Standard III indicate that documentation must be concise, comprehensive, accurate, continuous, systematic, and retrievable. The other standards regarding additional aspects of the nursing process require that the nurse's interventions must be documented in this manner. In addition, the plan of care, the problems identified, the responses of client and family, and the nurse's evaluation and revisions of the plan of care must be documented according to these criteria.

Stewart (1986) discussed the design and implementation of a computerized clinical documentation system for home

health care. This system was designed in response to the need dictated by burgeoning home health care industry demands and by a reimbursement method based on the principle of accountability. "Organizations are now responsible for knowing the type of services covered under the program and providing adequate documentation to justify those services" (p. 45). Stewart (1986) suggested that hospital nurses practicing in the new specialty area of home health nursing need to learn the difference between the hospital and home care requirements in the current health care delivery system. She also stated that the one difference that impacts virtually every nurse is documentation. In most instances, neither nursing education nor hospital experience adequately prepared the nurse to meet the needs of qualitative and quantitative documentation required to insure reimbursement (p. 45). As yet, no evaluation of this system of qualitative and quantitative documentation of the care provided is in the literature.

Articles which presented guidelines for documentation to best ensure reimbursement predominated in the literature about home health care documentation (Holloway, 1984; Jacob, 1985; Monica & Yuan, 1988; Omdahl, 1987; Omdahl, 1988; Shamansky, 1988). These articles were focused on Medicare regulations as well as the common, current interpretations of those regulations by fiscal intermediaries. They

addressed the major concern of how to avoid reimbursement denials due to faulty documentation which might imply lack of agency compliance with regulations for provision of services. The guidelines included instructions for documenting the initial plan of care and additional physician's supplementary orders as well as other necessary documents.

Multiple strategies for documentation of the individual client visits were specified, and reimbursable services were defined and clarified. The researchers' directives are all similar: be specific, be precise, be complete, be accurate, spell out details, "paint a complete picture" of each visit, be objective, add client's subjective comments, and be comprehensive. The delineated strategies advocated the use of certain accepted terminology as well as the avoidance of particular words because experience had shown them to be "red flags" to chart reviewers of the fiscal intermediaries. Over all, nurses were instructed to organize the data to clearly show, without any room for doubt, the relationship between the data base, the problems assessed, the plan of care, the interventions performed, the clients' responses, and the evaluation of daily progress. The literature did not reveal any studies about how well nurses implement these current strategies in the documentation of daily visits to home health care clients.

Chapter 3

RESEARCH DESIGN AND METHODOLOGY

Research Design

A descriptive, qualitative field research study was appropriate for this topic because of the lack of research about the documentation of daily progress notes by home health care nurses. Before research can be done in a quasi-experimental mode, the existing components, parameters, and possible variables involved in this area of study must be identified.

In explaining the characteristics of field research, Wilson (1988) describes fieldwork as "a mode of scientific inquiry which immerses the researcher in processes of day-to-day life," and the "field is the social-psychological area where the investigator gathers data to find answers to the central area of inquiry" (p. 369). Wilson explains that the features which characterize these studies are:

1. The researcher is the primary instrument for data collection via either face-to-face interviewing or participant observation (p. 370).

2. Data collection and analysis go on in the natural setting as the investigator learns about the variables and how they go on simultaneously and change under usual and unusual circumstances. This process is in contrast to

trying to control all but the designated variables under scrutiny (p. 370).

3. The logical progression of field research is different from traditional research that begins with a hypothesis and proceeds in a linear manner to data which are analyzed to confirm or refute the hypothesis. Field research starts with studying much data and proceeding to many tentative hypotheses in a multidimensional process, through data analysis, to end with perhaps many propositions or concepts. It requires a combination of inductive and deductive thinking (p. 370).

4. Field researchers must make special accommodations to the ethical principles of research because their work is usually conducted in close association with the people and situations they study. No matter how unobtrusive, field research always pries into the lives of informants and includes a particularly high risk for invasion of privacy, inconvenience to subjects, and conflict of interest. Fieldwork also requires the researcher to gain as intimate an understanding as possible about the field being studied and to define that world from the perspective of those being studied (p. 390).

5. Data collection in field research begins with the researcher casting a wide net and initially mapping the setting to become oriented to its various social, spatial,

and temporal dimensions. Then the researcher is guided by categories and ideas that emerge in the analysis (p. 390).

Setting and Sample

The field for this study consisted of the private homes of 22 clients receiving home health care nursing services. These services were provided by seven staff nurses in three Medicare certified home health agencies in Santa Clara County. This setting was accessed by initially examining the telephone book yellow page advertisements for home health care agencies in the area which were designated as "Medicare certified." This required designation insured that the nursing services would be of the skilled, intermittent type suitable for this study. Six agencies in the South Bay and Mid-Peninsula area were telephoned to contact either a nursing supervisor or a director of nursing to briefly explain the research and request an appointment to elaborate on the project. Of these six, four supervisors granted interviews to the researcher.

During each of these interviews, the research proposal as approved by the Human Subjects Review Board at San Jose State University (Appendix A) was presented and explained. One home health agency supervisor indicated that the proposal did not have the information required by her agency's Research Review Board, and permission was denied. The remaining three nursing directors were interested in the

project as presented and signed the Research Project Authorization Form (Appendix B).

Rather than have the researcher present the project to the agencies' staffs and request volunteers, all three directors preferred to present the proposal themselves at a staff meeting. They agreed to request only registered nurses (RNs) with a status position (i.e., with specific, scheduled workdays each week) to volunteer for the study. One of these directors actually appointed status position RNs to participate in the research, pending their signed consents on the day of the observations.

The criterion of being a registered nurse with a status position was decided on the basis of the researcher's earlier telephone survey of 10 Bay Area agencies. In that survey, the representative from each agency stated that the agency employed mainly RNs and preferred those with baccalaureate degrees (BSN) and Public Health Nurse certification (PHN) when available. The criterion of a status position rather then a per diem position (i.e., non-specific schedule, working day-by-day as needed) was instituted to ensure that the nurses in the sample would be those whose experience came from working regularly. These staff nurses would be expected to be knowledgeable and skilled in the implementation of appropriate documentation as required by agency and government regulatory guidelines.

Additionally, status position RNs were seen as more likely to have experience in continuous case management of client services. The case management process does require considerable knowledge of appropriate documentation procedures, as well as the confidence and skill to be able to work autonomously.

In an effort not to inconvenience staff unnecessarily, it was decided that the researcher would accompany each staff nurse for one half day, either morning or afternoon, to observe three or four client visits. This schedule coincided with the common routine of the home health nurses and included routing morning visits in one area and then returning to the office for lunch and messages. Afternoon visits were routed to another area. Nurses returned at the end of the day to the office to complete paperwork and plan for the next day.

Due to the researcher's own work schedule, observations were limited to either Thursdays or Fridays and to not more than 1 day each week. Tentative dates for the next 2 months were then set for the researcher to visit the agency and join the staff nurses. Thus, the RN sample of convenience was limited to the status position RNs who were scheduled and available on the days which the researcher planned to perform the visit observations.

The convenience sample consisted of seven RNs who were: (a) Caucasian, (b) female, (c) between the ages of 24 and 35, and (d) employed in a part time or full time status position in a Medicare certified home health care agency. On the week of observation, one of the RNs had just changed her status from full time to per diem, but was still accepted for purposes of the research.

Data Collection Procedure

On the assigned date, the researcher arrived at the agency and was introduced by the director to the staff RN. The staff nurse had volunteered or been appointed and had consented to be part of the sample. The researcher explained the project in general terms as exploratory field research about home health nursing visits and documentation. If the exact focus of the research had been explained, the researcher believed that the nurses might have deviated from their usual behavior in making and documenting client visits. This deviation would not be useful to the field research. The nurse signed the consent form Agreement to Participate (Appendix C) while still in the agency office and before any client was contacted to schedule the time of the morning visit. Additionally, the form entitled Nurse Participant Demographic Data Questionnaire (Appendix D) was completed by the nurse herself or by the researcher during an interview.

The demographic data included standard information about the staff nurse's education and experience as well as her position and duties in the home health care agency. Each RN was assigned a number for purposes of increased objectivity and confidentiality. This number was used later to identify the nurse on the researcher's visit observation notes.

Also, each participating nurse was given the Verbal Consent of Client form (Appendix E) which allowed the researcher to visit during each planned client visit. As the nurse phoned the client to arrange the home visit for the day, she requested the client's consent for the researcher to accompany the nurse into the client's home. Verification of the consent was documented on the above mentioned form. No contacted client refused to allow the researcher to enter the home and observe the visit. Thereafter, client confidentiality was ensured by referring to the client by initials on data sheets and observation notes.

When the client visits were scheduled and confirmed, the researcher accompanied the staff nurse in the nurse's vehicle to the clients' homes. This arrangement facilitated making joint visits efficiently. The time spent riding with the nurse was used by the researcher to complete a background Client Data Sheet (Appendix F) about the client

to be visited or to complete the form's post-visit data section about the client whose visit had just been completed. As the nurse entered each client's home, the researcher was introduced, and the client's consent for the researcher's presence was validated. The staff nurse explained that the researcher was also a nurse who was doing research about home health nurses and would be making notes of the events of the visit. In an effort to be an unobtrusive, non-participating observer and to allow events to proceed as they might normally occur, the researcher stationed herself on the periphery of the area of nurse-client interaction in the home. The researcher did not enter into conversation and moved as little as possible in an effort to avoid distracting the client and to avoid inviting conversation with the visit participants.

Most of the time this non-intrusion was completed successfully. Instances of participation did occur when, despite the researcher's instructions to "ignore the researcher during the visit," the client included the researcher in conversation or the staff nurse invited or requested the researcher to come closer to observe some aspect of client care.

This occasional involvement was anticipated as the researcher chose the role identified by Wilson (1988) as that of "the participant-as-observer" (p. 374). Not a

complete observer and not a complete participant, this role is one in which entree is gained to the field of study by making participants aware of the research being conducted. According to Wilson (1988):

> The major problem of this role is that participants may come to expect the field worker to become more of a colleague and participant than he or she is capable of without jeopardy to the research. Nurses are particularly vulnerable to these conflicting demands when conducting research in a health care setting where they possess the skills to actively intervene in situations and, in fact, are accustomed to doing so. (p. 374)

Data Collection Instrument

Wilson (1988) states that a field researcher must have a system for remembering observations and retrieving and analyzing them by taking notes on a small pad or clipboard (p. 380). To facilitate remembering, recording, and retrieving observations, a tool was developed based on the expected occurrences of the visit. This Visit Observation Notes form (Appendix G) was attached to a clipboard which the researcher used to record field notes of each visit.

On the observation form, the visit was identified by the date, the client's initials, and the nurse's assigned number from the Demographic Data Questionnaire. The visit

setting was described to document data about environment or caregivers which might affect the nurse or client interactions during the visit. The "Key: types of notes recorded" at the bottom of the form was based on Schatzman and Strauss's recommendations as described by Wilson (1988) in Research in Nursing. Using this key, the types of notes were coded in the narrow columns as either "ON" for observation of nurse or "OR" for observation of response by client or caregiver. Additional data designations were coded as "MN" for methodological notes of instructions or reminders, "TN" for theoretical notes for analysis, and "PN" for personal notes of a reflection by the researcher.

The researcher's previous experiences in home health care nursing--especially as staff nurse, case manager, and utilization reviewer--provided the familiarity necessary to be oriented to the various dimensions of the research setting. These experiences allowed the researcher to begin mapping the setting, prior to the actual data gathering itself, by anticipating categories into which the data could be organized.

The column format of categories was designed to facilitate the organized recording and retrieval of data as the nurse and client actions were documented in objective terms. The columns were based on the regulations from the Health Care Financing Administration's (HCFA) Medicare

Manual for Home Health Agencies (1984). These regulations define the skilled nursing services which are allowed by Medicare's Home Health Care Benefit. In general, these regulations categorize the allowable (i.e., reimbursable) nursing services into three main classification:

1. Skilled observation and assessment activities of the client's physical, functional, and psychosocial condition such as taking a blood pressure, auscultating lung sounds, or pressing a tibial bone to determine edema.

2. Teaching/training and supervision activities to instruct the client or caregivers in patient care, such as teaching about diabetic diet exchange lists or demonstrating the safe transfer of a client from the bed to a wheelchair.

3. Performing direct Hands-on care such as removing a clogged gastrostomy tube, giving an injection, or cleansing and dressing a wound (Olson, 1986).

This column format allowed the researcher to group the data as it was being gathered. For completeness, a fourth column was included for grouping behaviors that would not fit into the aforementioned three. In order to qualify for reimbursement from HCFA, nursing visits must include, but are not necessarily limited to, the three main classifications of skilled nursing services which are deemed medically and reasonably necessary for the client's condition. Activities for the "Other" column were those

which are not presently considered skilled nursing, but are often performed by home health nurses as the need arises. These activities stem from the profession's own scope of practice which does include preventive care, counseling, and case management of client services and resources. Also, this fourth category could include urgently needed personal care services which would ordinarily be performed by a family caregiver or home health aide in the nurse's absence.

This tool was appropriate for recording the activities observed in objective, behavioral terms. The proper classifications for the data were selected by the researcher based on her experience. Hands-on activities were observable by the researcher and recorded. Assessment and observation activities were also observed as the nurse gathered data physically or verbally by asking questions of the client or caregiver. Teaching and training activities consisted of any instructions or demonstrations that were given, planned, or spontaneous.

The home health care nurses usually documented their visits partially while still in the client's home and completed the visit notes afterwards, either in the vehicle or in the office at the end of the morning's visits. Each nurse planned and completed three to four visits in the morning and had an additional one to three visits planned for the afternoon. These visit notes were xeroxed for the

researcher; the client and agency names were obliterated on the copy to retain confidentiality of client information. Two of the nurses stated that they did not customarily complete any of their notes until the end of the day. They preferred to get all the traveling and visits completed by early afternoon and to spend the last 2 or 3 hours in the office completing paperwork. In those instances, the researcher left a self-addressed, stamped envelope for the nurse to mail copies of the visit notes later that day. The researcher received the copies within a week in each instance.

Over a period of 2 months, seven home health care staff nurses were accompanied for approximately 3 to 4 hours each while the nurse made two, three, or four home visits. The number of visits varied with each nurse. This variation was the result of: (a) the nurse's caseload and visit schedule as planned and as revised on the day of the researcher's observations, (b) the nurse's planned driving route based on client proximity and known traffic patterns, (c) the client's daily schedule of activities, and/or (d) client visits previously planned which could not be accomplished due to a client's last minute visit to the physician. In one instance, the homebound client was unaware of road construction which had temporarily blocked access to the

home, and the nurse was unable to visit the client that morning.

All but two of the visits were considered routine follow-up visits of a client already established on service. One of the remaining visits was an "intake" visit for assessing a new client and planning needed services. This visit was lengthy, and the nurse used different, more extensive documentation forms than were used for the routine visits. The other exception was a visit solely for the purpose of supervising the home health aide services. This visit was very brief and also was documented in a different manner from routine nursing visits.

The researcher accepted whatever visits developed from the nurse's schedule for that half day of the nurse's assigned meeting with the researcher. The initial goal was to observe at least 20 visits by accompanying five nurses making four visits each. Over the 2 months, however, the researcher accompanied seven nurses and obtained a total of 22 visit observations. Of these 22 visits observed, only the 20 routine follow-up visits were utilized for analysis purposes.

During that 2 months of data gathering, the nurses' demographic data and visit note copies were gathered and matched with the client information and researcher's observation notes for each visit. On initial examination of

the nurses' visit documentation notes, the researcher identified several general tendencies which helped determine how the visit notes would be evaluated. Generally, the researcher noticed: (a) the visit notes varied in the amount and type of details recorded; (b) the forms for the visit notes were completed in a variety of ways with regard to completeness, organization, and identification of patient problems; (c) the data were often grouped and generalized; (d) data about client outcomes or responses were recorded infrequently; and (e) some nurses' visit documentation notes recorded activities which were not observed and recorded by the researcher on her observation notes.

Data Analysis Criteria

In order to analyze the accumulated visit data, the nurses' visit documentation notes were evaluated in comparison to the researcher's visit observation notes. The researcher used the ANA's Standards of Home Health Nursing Practice to develop evaluation criteria which also reflected major points in the current strategies about documentation for reimbursement. These criteria were the basis for the comparison of the staff nurses' visit documentation notes with the researcher's visit observation notes. The five criteria developed for evaluating the nurses' visit documentation were the following: (a) the comprehensiveness of data about nursing interventions, (b) the

comprehensiveness of data about client or caregiver's response to nursing interventions, (c) the accuracy in recording the visit data correctly, (d) the accuracy of data in identification of important aspects or foci of the visit, and (e) the systematic organization of data on the visit note.

As a rating method for comparing the nurses' visit documentation notes to the researcher's observation notes, the researcher adapted the percentage compliance scale currently used by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) in their 1991 Accreditation Manual for Hospitals, Volume II "Scoring Guidelines" (pp. 5-6). This scale labels and scores compliance with a standard in the following way: (a) 91% to 100% indicates substantial compliance for a score of 1, (b) 76% to 90% indicates significant compliance for a score of 2, (c) 51% to 75% indicates partial compliance for a score of 3, (d) 25% to 50% indicates minimum compliance for a score of 4, and (e) less than 25% indicates no compliance for a score of 5.

An adaptation of this percentage compliance scale was devised in order to allow for scoring instances of false compliance by over-documentation (i.e., documentation which reflected more than what the researcher observed to have actually occurred). The intervals of the JCAHO scale were

expanded to cover "false compliance" as well as lack of compliance with the criteria. Table 1 shows the adapted percentage compliance scale for deriving a documentation score after evaluation of the visit notes for compliance with standard criteria.

Table 1

Percentage Compliance Scale for Deriving Scores

Percentage of Compliance or False Compliance	Classification	Score
91%-100%	substantial compliance	1
76%-90% or 101%-115%	significant compliance	2
51%-75% or 116%-149%	partial compliance	3
25%-50% or 150%-175%	minimal compliance	4
< 25% or > 175%	non-compliance	5

Chapter 4

RESULTS AND DATA ANALYSIS

Wilson (1988) writes that one procedure in field research for analyzing unstructured qualitative data is called content analysis. She describes the basic steps involved in performing content analysis as: (a) deciding on what the unit of analysis will be, (b) borrowing or developing the set of categories, and (c) developing the rationale and illustrations to guide the coding of data into categories (p. 408).

This study was done to answer the following questions:

1. What characteristics must be evident for the visit note to (a) document adequately for reimbursement purposes, and (b) document adequately for purposes of compliance with professional standards?

2. How do home health nurses manage this task of documenting each client visit?

3. What variables or conditions are identified as influencing this process and to what extent?

Data Analysis Process

The data analysis consisted of four major steps. The first step was a content analysis of the data collected in the researcher's observation notes (RON). The second major step was a content analysis of the data collected in the nurses' visit documentation notes (NVDN). The third step

involved the coding of both sets of data into 17 categories of the client's biophysical status and functional aspects. The coded data from the RON and the NVDN were then compared. The final step was a content analysis scoring of the NVDN coded data according to five descriptive criteria which were derived from professional standards about home health nursing practice.

The researcher obtained scores for: (a) each nurse's documentation of an individual visit, and (b) each nurse's collective documentation of all the visits she performed. This process provided a way to identify whether there were differences between nurses in how they documented nursing services and client responses occurring during the home visit. Figure 1 and Figure 2 show a schematic model for the content analysis process of the field research data in this study. Each of the steps delineated above will now be discussed.

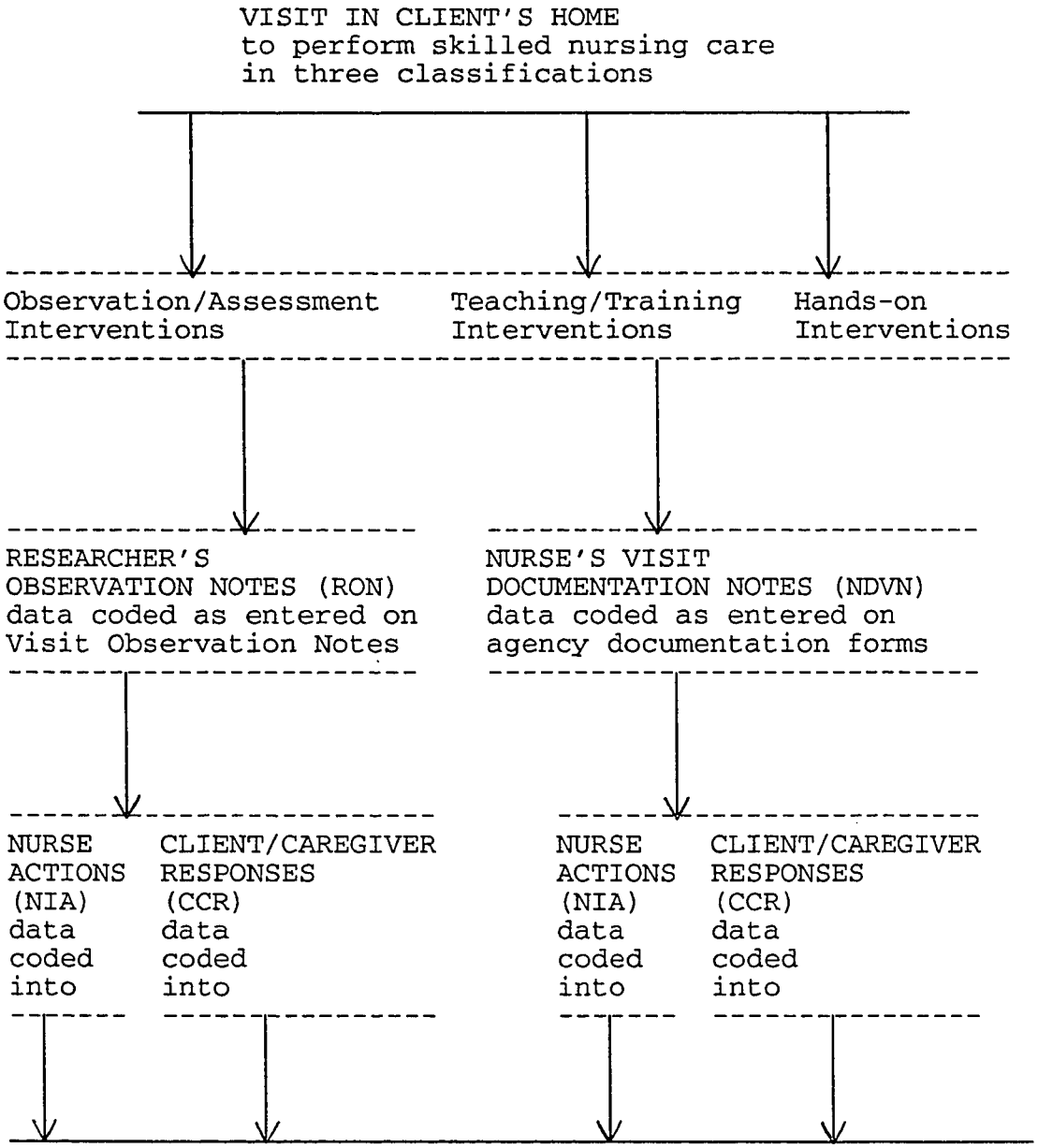

Figure 1. Field Research Data Analysis Process - Part 1

17 CATEGORIES (CAT) FOR NURSE ACTIONS OR CLIENT/CAREGIVER RESPONSES RE: BIOPHYSICAL STATUS AND FUNCTIONAL ASPECTS

1. Eye/ear/nose/throat
2. Neurological
3. Cardiovascular
4. Respiratory
5. Gastrointestinal
6. Genitourinary
7. Musculoskeletal
8. Endocrine
9. Integumentum
10. Psychosocial
11. Nutrition/Hydration
12. Pain/Comfort
13. Sleep/Rest
14. Activity Level
15. Medications
16. Safety
17. Health Maintenance Management

RON coded data analyzed and set as the STANDARD for comparison

1. Eye/ear/nose/throat
2. Neurological
3. Cardiovascular
4. Respiratory
5. Gastrointestinal
6. Genitourinary
7. Musculoskeletal
8. Endocrine
9. Integumentum
10. Psychosocial
11. Nutrition/Hydration
12. Pain/Comfort
13. Sleep/Rest
14. Activity Level
15. Medications
16. Safety
17. Health Maintenance Management

NVDN coded data analyzed and compared with STANDARD to obtain derived SCORES

1. Comprehensiveness of recording nursing intervention activities (COMP-NIA)
2. Comprehensiveness of recording client/caregiver responses (COMP-CCR)
3. Accuracy of recorded data (ACC-DATA)
4. Accuracy of identified foci recorded (ACC-FOC)
5. Systematic organization of recorded data (SYST-ORG)

Figure 2. Field Research Data Analysis Process - Part 2

Content Analysis of Researcher's Observation Notes

The first component in the process of the content analysis of the researcher's observational data was done prior to entering the field for data gathering. A tool was devised for recording visit observations of nurse and client or caregiver behaviors. These behaviors were anticipated to be classified into the three main types of nursing intervention activities: (a) observation and assessment, (b) teaching and training, and (c) hands-on tasks. These classifications provided the framework for organizing and recording the behaviors occurring during the visit. The amount and type of details observed for each type of nursing intervention activity were then identified according to these three classifications.

On examination of the researcher's observation notes (RON), the researcher identified a variety of specific nursing activities within each of the three main classifications of nursing interventions. For example, the observation and assessment classification included activities such as: (a) palpating pedal edema, (b) taking an apical pulse, or (c) testing blood with a small machine to determine glucose levels. The teaching and training classification included activities such as: (a) instructing client in 1200 calorie diabetic diet, (b) instructing client

to notify the nurse when signs and symptoms of fluid retention are evident, or (c) instructing client about the side effects of a medication. The hands-on classification included activities such as: (a) changing a urinary catheter, or (b) performing wound care on a pressure sore.

General analysis of the researcher's observations notes for all the visits revealed that most data recorded nursing intervention activities in the observation and assessment classification. Of the 17 client categories available, the range of categories containing data in this observation and assessment classification was from 7 to 11, with an average of 11 categories and a mode of 13 categories. In the teaching and training classification, the data ranged from 1 to 9 categories, with a bi-mode of 8 and 3 categories. The average number of client categories in this classification was 5. In the hands-on classification, the data ranged from 0 to 7 categories, with a mode of 1 category and an average of 2 categories.

This distribution of data in the three classifications indicates that the majority of nursing intervention activities were concerned with observation and assessment, which are basic to every home health care client's plan of care. Teaching and training activities were also done for every client, but less frequently, and were dependent on the client and caregivers' needs for instructions. Hands-on

activities were performed for clients only as required by the medical plan of care. For some clients, there was little, if any, need for hands-on care by the nurse. Further analysis of how these data were distributed among the three classifications of nursing intervention activities was not done because it was not relevant to this field research.

A general review also revealed that the researcher's observation notes did not record generalities. Rather, the simplest elements of data were the specific behaviors which described most exactly how a nursing intervention activity (NIA) was performed. For example, for an intervention activity in the observation and assessment classification, the following details of behavior were recorded: (a) if the pulse was taken radially or apically, (b) if the blood pressure was taken with the client sitting or standing or lying, and (c) who used what type of method to determine the client's blood glucose level.

The researcher observed the nurse during the teaching intervention activity of instructing a client about a diabetic diet. The researcher recorded the following content while the nurse taught: (a) a list of foods not allowed, (b) a list of foods allowed in abundance, (c) how to use food exchange lists, (d) how to accurately measure portion sizes, (e) acceptable food preparation methods,

(f) how to time meals and snacks, and (g) how to manage sick days.

The researcher observed a nurse during hands-on nursing intervention activities. One hands-on intervention activity was performing wound care, and the nurse's observed behavior included the following specifics: (a) assessing dried drainage on the dressing; (b) measuring the wound for length, depth, and width; (c) assessing the color and condition of peripheral tissues; (d) assessing the wound bed for granulating or necrotic tissue; and (e) using specific methods and types of supplies to clean and dress the wound.

In evaluating the researcher's observations of the client or caregiver responses (CCR), the fact that there was a response recorded in behavioral terms was considered the simplest element of data to code. The degree or amount of specifics or details versus generalities was not an issue for this data. For example, in response to the nurse instructing the client about foods which should not be included in a 2-3 gm sodium diet, the client responded, "Oh, I don't like pretzels anyway." The client later added, "You mean I can't ever eat another dill pickle?" In analysis of this conversation, two distinct units of client response to the nurse were identified. In another incident, an example of one unit of response occurred when the nurse instructed the client in diabetic emergency measures after instructing

in the signs and symptoms of hypoglycemia and hyperglycemia. The researcher recorded that the client was observed to merely nod in understanding at the end of the instructions.

This type of detail observed and recorded by the researcher corresponded to what the earlier cited literature referred to as "being specific," "giving details," or "painting a picture" about the visit. These details were the data answering the questions who, what, where, why, and how, and were documented in behavioral terms as the researcher recorded the events of the visit.

This recognition of the amount of detail recorded by the researcher in the three main classifications of nursing intervention activities was sufficient to allow for the use of the researcher's observations as the complete picture of the visit. This picture of the client visit, created by the researcher's observation notes (RON), was the standard against which the nurse's visit documentation notes (NVDN) were compared and evaluated.

Content Analysis of Nurses' Visit Documentation Notes

The nurses' visit documentation notes were the next body of data to be analyzed. For every visit, the organization of the nurse's notes was dictated primarily by the agency's forms for client visit documentation. Each agency had a specific, pre-printed form which combined

checklists and narrative sections. Many of these narrative sections were organized into columns or divided portions. The narrative sections and checklist portions of the forms often matched the three main classifications of skilled nursing intervention activities (NIA) mentioned previously. Only one form designated specific spaces for client or caregiver responses to interventions (CCR). Most forms addressed a similar set of biophysical and functional human systems, usually in a checklist format. In this way, the nurse's task of documentation of the visit was already structured by the form to include vital information in an organized manner. There were differences in the amount and type of space allowed for details.

Coding of RON and NVDN Data

The next step in the content analysis was to develop the rationale for the coding and sorting of data from both the researcher's observation notes (RON) and the nurses' visit documentation notes (NVDN). This coding needed to be done in a manner which allowed for comparisons of similarities and differences in how the events were recorded by the researcher and the nurses. During the visit, the researcher observed and documented events in detailed, chronological order in behavioral terms on the visit observation tool. However, the nurses documented in data bits and data groups in a semi-organized format according to

the agency's documentation form, usually after the visit was completed.

Initially, an attempt was made to find a single unit of data analysis which could be applied to both the researcher's observation data of behaviors and the nurses' documentation data of nursing interventions and client or caregiver responses. An attempt was made to code by descriptors, either words or phrases which were analogous to the specifics or details mentioned earlier in describing how a nurse carried out a specific activity. However, this method became mere word counting and was discarded as unreliable and not significant for the purposes of this field research.

Instead, the primary focus for the comparison of the nurses' visit documentation notes data (NVDN) with the researcher's observation notes data (RON) was identified as the 17 categories (CAT) of client biophysical status and client functional aspects. These were the categories commonly addressed by nursing intervention activities (NIA) with resultant client or caregiver responses (CCR). The main process for comparison of the nurses' data with the researcher's data was achieved by devising a Data Analysis Tool (Appendix H) which allowed for coding NVDN and RON data into the 17 client categories.

These categories were developed because the content of the NVDN and the RON data fell into two main areas concerning either: (a) aspects of a client's biophysical status, or (b) aspects of a client's functioning. In addition to being inclusive for all the data obtained, these categories were mutually exclusive, separate, and independent.

Client biophysical status categories are the common components of a client head-to-toe systems' review. There are nine categories:

1. Eye/ear/nose/throat
2. Neurological (central and peripheral)
3. Cardiovascular
4. Respiratory
5. Gastrointestinal
6. Genitourinary
7. Musculoskeletal
8. Endocrine
9. Integumentum

The client's functional aspects, however, often involve multiple body systems and can overlap each other. These aspects are similar to the categories of functional health patterns often found in a systematic assessment of activities of daily living. The eight functional categories

are described and differentiated to be mutually exclusive as follows:

1. Psychosocial is affective and cognitive behavior, perceptions and social interaction, and relationships with significant others.

2. Nutrition/Hydration is the consumption of food and fluids.

3. Pain/Comfort is the coping response to pain or stress and comfort measures.

4. Sleep/Rest is patterns and responses of sleep and rest.

5. Activity Level is the amount and type of activities of daily living according to ability and energy and assistance needed.

6. Medications is the use, effects, side effects, and safe administration of any medication (whether for sleep assist, pain management, or respiratory problems).

7. Safety is the recognition and prevention of risk factors to prevent harm from home or environmental factors to client and significant others. For example, individualized instruction in safety measures to ensure infection control (e.g., disposal of needles) would be coded here. However, the use of standard sterile technique in performing a catheter change would be coded in the Genitourinary category.

8. Health Maintenance Management is the ability to identify, manage, and/or seek help or material resources or social supports to maintain health status in the current health care setting (Gordon, 1985, p. 38).

These 17 client categories (CAT) were used for coding data both from researcher's observation notes (RON) and from the nurses' visit documentation notes (NVDN). First, for each visit in the sample, the RON were marked with a category code on the original Visit Observation Notes form (Appendix G) and entered onto the Data Analysis Tool (Appendix H) to record the data in the appropriate categories. The CAT-NIA result of the RON indicated how many of the 17 categories were addressed by the nurse performing either an observational, instructional, or hands-on nursing intervention activity during observation. The CAT-CCR result of the RON indicated how many of the 17 categories were addressed by a response from the client or caregiver during observation. A CAT-NIA result and a CAT-CCR result were recorded for each visit observed. Clusters of data were identified on the Data Analysis Tool with large, solid dots and recorded as important aspects or foci of the visit.

The data from the nurse's documentation (NVDN) were then coded onto the Data Analysis Tool in a similar fashion, although with more difficulty, because the agency forms

encouraged some grouping of data into summaries. These groupings came from multiple occurrences of the nurse addressing any of the 17 categories throughout the visit. Therefore, it was more difficult to determine the number of occurrences to tally for the identified category on the Data Analysis Tool.

As a result, categories addressed by groupings or clusters of data by the nurse's documentation (NVDN) were also identified on the Data Analysis Tool with large solid dots. Checklist or brief answer portions of the visit notes were more easily coded into categories. By counting the number of categories addressed by a nursing intervention activity, a CAT-NIA result was obtained. By counting the number of categories addressed by a client or caregiver response, a CAT-CCR result was obtained. A CAT-NIA result and a CAT-CCR result were recorded for each nurse's visit documentation note. Any instances of the NVDN showing incorrect information, i.e., not confirmed by the information in the corresponding RON, were marked and counted as "errors." The number of identified important aspects or foci in the NDVN were counted and recorded.

The individual NVDN were analyzed on a random basis and in a random order to maximize researcher objectivity in coding the data. After the coding was completed, each of the seven nurses was randomly assigned a letter from A to G

to more simply identify the nurses for the tabulation of results and derived scores of the coded data. Also, each visit by a nurse was randomly designated by a number with the letter, depending on the number of visits performed by the nurse. Thus, the NDVN are individually identified in the manner of A-1, A-2, A-3, A-4; C-1, C-2; and D-1, D-2, D-3, etc.

A sample of how the data were coded is described here for a part of visit D-1. The RON for visit D-1 consisted of two pages of recorded observations which were coded into the 17 categories. For example, the nurse stated, "She needs to be up and walk around more." This remark was coded as one nursing intervention activity (NIA) in the Activity Level category of the teaching/training classification. The nurse examining the transparent dressing on the client's arm wound was coded as 1 NIA in the Integumentum category of the observation/assessment classification. The activities of the nurse measuring, cleansing, applying ointment, and re-dressing the arm wound were coded as 4 NIA in the Integumentum category of the hands-on classification. The behavior of the client not looking at her arm or speaking to the nurse during the dressing change was coded as 1 client/caregiver response (CCR) in the same category and classification.

The nurse stating to the client's daughter, "She seems more sleepy today" (i.e., client was lethargic while sitting up in wheelchair) was coded as 1 NIA in the Neurological category of the observation/assessment classification. The daughter responding, "She's been more sleepy the past 2 days. Do you think it could be her new meds?" was coded as 1 CCR in the same category and classification. The nurse instructing the client, "Be sure someone is with you when you try to get up" was coded as 1 NIA in the Safety category of the teaching/training classification. The daughter then responding, "Sure, okay" was coded as 1 CCR in the same category and classification. The nurse palpating the client's legs for pedal edema was coded as 1 NIA in the Cardiovascular category of the observation/assessment classification. The remaining data from the RON were similarly coded on the Data Analysis Tool.

For the example visit D-1, the results of all the RON data coded into categories were: (a) 12 of the 17 categories were addressed by a nursing intervention activity for a CAT-NIA result of 12, (b) 9 of the 17 categories were addressed with a client or caregiver response for a CAT-CCR result of 9, and (c) data clusters were identified in the two categories of Integumentum and Safety.

A sample of how the data were coded for the nurse's visit documentation notes (NVDN) of example visit D-1 is

also presented. On the checklist section of nurse D's agency's form, the NDVN recorded "alert" for the Neuro assessment, which was coded by the researcher as 1 NIA in the Neurological category of the observation/assessment classification. The NVDN also recorded "fair" for Activity tolerance, which the researcher coded as 1 NIA in the Activity Level of the observation/assessment classification. The NVDN identified the arm wound as one focus of the visit, and recorded multiple details about the wound appearance, drainage, cleansing, and dressing change. The researcher coded the wound care specifics as multiple NIA in the Integumentum category in the hands-on classification and further identified the data cluster as one focus of the visit. No wound size was documented and this omission was recorded by the researcher as 1 error.

The NVDN also had "RN discussed home safety--not to leave patient unattended and keep sharp objects out of reach" recorded which the researcher coded as 2 NIA in the Safety category of the teaching/training classification. The only client/caregiver response to this recording on the NVDN was "daughter receptive to suggestions" which the researcher coded as 1 CCR in the Safety category of the teaching/training classification. The NVDN also had appetite recorded as "good" which was coded as 1 NIA in the Nutrition/Hydration category of the observation/assessment

classification. However, because this NIA was not observed or recorded in the RON, it was marked on the NVDM as an error of over-documentation by the nurse. The remainder of the NVDN data were similarly coded into the categories and classifications.

For the visit D-1, the NVDN data were coded for the following results. The NVDN showed that 10 of the 17 categories were addressed with data about nursing intervention activities for a CAT-NIA of 10, and only one category was addressed with data about a client or caregiver response for a CAT-CCR result of 1. Two instances of inaccurate recording on the NVDN were coded as errors, and the number of foci identified by the nurse was 2. No errors were found in the way the nurse used the agency form for organizing visit information data. All the data of the researcher's observation notes and the nurses' visit documentation notes for the 20 sample visits were coded and recorded by similar rationale.

Content Analysis According to Documentation Criteria

The fourth step in the data analysis process included behaviorally defining the rationale for the five documentation criteria by which the coded data of the

NVDN were evaluated. The rationale developed for the criteria were:

1. Comprehensiveness of the nurse's visit documentation note in recording nursing interventions (COMP-NIA) is the consistency between the amount and type of data recorded by the nurse with the amount and type observed by researcher. In the sample, this consistency is reflected by a comparison of the results of the CAT-NIA of the NVDN with the CAT-NIA of the RON for each visit. This result is the COMP-NIA score for each visit.

2. Comprehensiveness of the nurse's visit documentation note in recording client and caregiver responses (COMP-CCR) is the consistency found between the amount and type of data recorded by the nurse with that observed by the researcher. This consistency is reflected by a comparison of the CAT-CCR results of the NVDN with the CAT-CCR of the RON for each visit. This result is the COMP-CCR score for each visit.

3. Accuracy of the recorded data in the nurse's visit documentation note (ACC-DATA) is the degree to which the data recorded is correct when compared to the researcher's information. Errors due to significant omissions are counted along with errors due to lack of precision or accuracy. Errors due to the nurse's documentation of data which were not confirmed by the researcher's observations

were considered errors of over-documentation or "false compliance" and were also counted. These results are the ACC-DATA score for each visit.

4. Accuracy of the nurse's visit documentation note in the identification of important aspects or foci of the visit (ACC-FOC) is a comparison of the categories the nurse identified as a visit focus or problem on the NVDN with the RON data clusters identified on the Data Analysis Tool. These results are reflected by the ACC-FOC score for each visit.

5. Systematic organization of the visit note (SYST-ORG) is the appropriate use of the agency form for visit documentation. It is evidenced by the nurse placing information into designated locations on the form correctly. Errors noted by the researcher in the use of the client visit documentation form are the results which are reflected as the SYST-ORG score for each visit.

After the criteria and rationale were developed for the evaluation of the nurses' documentation, each NVDN was analyzed. The percentage compliance results from the Data Analysis Tool of the CAT-NIA, CAT-CCR, and errors noted in accuracy and systematic organization of the NVDN were used to determine compliance scores. The analysis resulted in derived scores for compliance with each of the five standard

criteria as well as an overall average derived documentation score for each nurse.

The system for deriving scores from compliance percentages is demonstrated in Table 1 on page 48. The most desired score to attain is a 1. This score indicates substantial compliance with the criteria standard and is derived from a compliance percentage of 91% to 100%. The next most desired score to attain is a 2, which indicates significant compliance with the criteria standard. This score is derived either from a compliance percentage of 76% to 90% or from a false compliance percentage of only 101% to 115% (due to a minimal degree of over-documentation). A score of 3 is not desired as it indicates only partial compliance with the criteria standard and is derived from a compliance percentage of 51% to 75% or a false compliance percentage of 116% to 149%. Scores of 4 or 5 similarly are undesirable as they indicated minimum or no compliance with the criteria standard.

Results

The score for the first criteria, regarding comprehensiveness in the documentation of nursing interventions, or COMP-NIA, was derived by comparing the CAT-NIA results of the NVDN with the CAT-NIA results of the RON. The percentage, COMP-NIA%, was based on the number of the 17 categories observed by the researcher which were also

documented by the nurse. The COMP-NIA% was then converted into a COMP-NIA score according to the scale described earlier in Table 1 on page 48.

For example, in visit D-1 cited earlier, the NVDN CAT-NIA of 10 was calculated to be 83% of the RON CAT-NIA of 12. The result was a COMP-NIA% of 83%. This became a COMP-NIA score of 2 according to the "System of Derived Scores Based on Percentage Compliance" shown in Table 1.

For the 20 visits in the sample, the COMP-NIA% of compliance ranged from 40% to 130%, with an average of 88.5% and a mode of 51% to 75% agreement of NVDN with RON. Instances of over-documentation resulted in COMP-NIA% of greater than 100 in false compliance between the standard RON and the NVDN.

The score for the second criteria of comprehensiveness in the documentation of client or caregiver responses, or COMP-CCR, was derived for each visit by comparing the CAT-CCR results of NVDN with the CAT-CCR results of the RON. The COMP-CCR percentage was based on the number of the 17 categories observed by the researcher which were also documented by the nurse. The COMP-CCR% was then converted into a COMP-CCR score according to the scale in Table 1.

In example visit D-1, the CAT-CCR of the NVDN was 1 and the CAT-CCR of the RON was 9. These results from the Data Analysis Tool demonstrated a COMP-CCR% compliance of 11% for

a COMP-CCR derived score of 5, again using Table 1. For the 20 visits, the range for COMP-CCR% results was 0% to 125% compliance with the standard, with an average of 45% and a mode of 0% to 50% compliance with the standard. Instances of over-documentation (false compliance) resulted in COMP-CCR% of greater than 100% in compliance between the standard RON and the NVDN.

Table 2 on page 73 shows the derived scores for comprehensiveness of data recorded and includes the COMP-NIA% of the visits and the derived COMP-NIA scores. It also shows the COMP-CCR% of the visits and the derived scores of COMP-CCR. The nurses are designated by letters A through G, and the scores for each visit are arranged according to the nurse who performed the visit. The most desired COMP-NIA and COMP-CCR percentages are 91% to 100% and 1 represents the most desired score, indicating substantial compliance with the standard (see Table 1). Also acceptable as an indication of significant compliance is the score of 2 which is derived from a compliance percentage of 76% to 90% (or conversely from a false compliance percentage of only 101% to 115%).

The score for the third criteria regarding the accuracy of the visit note in recording the data correctly, or ACC-DATA, was derived for each visit by counting the number

Table 2

Derived Scores: Comprehensiveness of Data Recorded

RN/ Client #	COMP-NIA%	COMP-NIA Score	COMP-CCR%	COMP-CCR Score
A-1	100	1	0	5
A-2	109	2	16	5
A-3	100	1	0	5
A-4	130	3	100	1
B-1	88	2	100	1
B-2	40	4	50	4
B-3	75	3	100	1
B-4	70	3	33	4
C-1	63	3	100	1
C-2	70	3	50	4
D-1	83	2	11	5
D-2	100	1	125	3
D-3	64	3	29	4
E-1	90	2	25	4
E-2	64	3	33	4
E-3	63	3	20	5
F-1	130	3	0	5
F-2	130	3	25	5
G-1	92	1	75	3
G-2	118	3	13	5

of errors found in the NVDN according to the definition of errors mentioned previously. The derived score ranges for ACC-DATA criteria are presented in Table 3 on this page. They were developed from the ACC-DATA results error range and a duplication of the percentage intervals found in Table 1. The desired standard was zero errors. Table 4 on page 75 shows the ACC-DATA errors and derived ACC-DATA scores for each sample visit.

Table 3

Derived Scores for ACC-DATA Criteria

Range of Errors in Sample = 0 - 7		
Compliance Ranges	Number of Errors	Score
91% - 100%	0 to .63	1
76% - 90%.	.64 to 1.68	2
51% - 75%	1.69 to 2.03	3
25% - 50%	2.04 to 5.25	4
< 25%	5.25 to 7.00	5

In the example D-1 visit, the two errors found in accuracy for the ACC-DATA criteria were converted to a derived score of 3. In the total sample of 20 visits, the

Table 4

Derived Scores: Accuracy and Systematic Organization of Data

RN/ Client#	ACC-DATA Errors	ACC-DATA Score	ACC-FOC Agreement %	ACC-FOC Score	SYST-ORG Errors	SYST-ORG Score
A-1	0	1	100	1	0	1
A-2	2	3	80	2	0	1
A-3	0	1	66	3	1	2
A-4	4	4	100	1	1	2
B-1	1	2	100	1	0	1
B-2	1	2	50	4	0	1
B-3	0	1	100	1	0	1
B-4	1	2	100	1	0	1
C-1	0	1	100	1	0	1
C-2	0	1	100	1	0	1
D-1	2	3	100	1	0	1
D-2	2	3	100	1	1	2
D-3	0	1	100	1	0	1
E-1	0	1	100	1	1	2
E-2	0	1	0	5	1	2
E-3	0	1	0	5	6	5
F-1	7	5	100	1	0	1
F-2	3	3	100	1	0	1
G-1	1	2	100	1	4	4
G-2	3	3	75	3	1	2

range of errors found was from 0 to 7, with a mode of 0 errors. The average number of errors was 1.4.

The fourth criteria concerned the accuracy of the visit note in identifying important aspects or foci of the visit for the ACC-FOC score. This score was derived by comparing the number of visit foci identified by the NVDN with the researcher's identified clusters of data in the RON. The percentage of agreement between RON and NVDN (or compliance of NVDN with the standard RON) was determined for each visit and was converted into a derived score using Table 1 on page 48. Table 4 on page 75 shows the ACC-FOC% of compliance and the derived ACC-FOC scores for each visit, grouped according to individual nurses.

For example, in visit D-1, the agreement between NVDN and RON in the identification of two foci resulted in a ACC-FOC of 100% compliance and a derived ACC-FOC score of 1. In the total sample of 20 visits, the compliance ranged from 0% to 100%, with an average of 83.5% and a mode of 100% agreement.

The score for the fifth criteria regarding systematic organization of the visit note, or SYST-ORG, was derived by counting the number of NVDN errors made in using the visit documentation form correctly. An error was made by entering data on a designated data field or space on the form incorrectly. This included errors made by incorrectly

identifying or labeling grouped data in the narrative sections. The derived scores for SYST-ORG are presented in Table 5 on this page as developed from the SYST-ORG results error range and a duplication of the percentage intervals found in Table 1 on page 48. The desired standard was 0 errors in the use of the form. Table 4 on page 75 shows the SYST-ORG errors found for each visit and the derived SYST-ORG scores for the entire sample.

Table 5

Derived Scores for SYST-ORG Criteria

Range of Errors in Sample: from 0 - 6

Compliance Ranges	Number of Errors	Score
91% - 100%	0 to .54	1
76% - 90%	.55 to 1.44	2
51% - 75%	1.45 to 2.94	3
25% - 50%	2.95 to 5.50	4
< 25%	5.50 to 6.00	5

In example visit D-1, the 0 errors found in the NVDN for the systematic criteria were converted to a derived SYST-ORG score of 1. On the NVDN for the 20 visits, errors

ranged from 0 to 6, with an average of .8 errors and a mode of 0 errors found.

Table 6 on page 79 displays all of the derived scores of the NVDN data for the documentation criteria of: (a) comprehensiveness of recording nursing intervention activities (COMP-NIA), (b) comprehensiveness of recording client and caregiver responses (COMP-CCR), (c) accuracy of documentation data (ACC-DATA), (d) accuracy of identification of visit foci (ACC-FOC), and (e) systematic organization (SYST-ORG). In addition, the five scores are averaged to determine an overall average documentation score for each visit. The asterisk shown on some of the visits indicates that the visit documentation was made by the nurse who was also acting as case manager for that client's home health services.

As described earlier, a score of 1 indicates substantial compliance and is most desired, and a score of 2 is also acceptable as it indicates significant compliance with the criteria standard. Of the 20 visits, only eight visits achieved an overall average derived score of 2.0 or less to demonstrate acceptable levels of compliance with the documentation criteria. A derived average score of higher than 2.0 indicates only partial, minimal, or no compliance with the documentation criteria standard. Of the 20 visits, 12 achieved overall average derived scores ranging from 2.2

Table 6

Total Derived Scores for Nurses' Visit Documentation Notes

RN/ Client#	COMP-NIA Score	COMP-CCR Score	ACC-DATA Score	ACC-FOC Score	SYST-ORG Score	Overall Total Score	Visit Average Score
A-1 *	1	5	1	1	1	9	1.8
A-2 *	2	5	3	2	1	13	2.6
A-3 *	1	5	1	3	2	12	2.4
A-4 *	3	1	4	1	2	11	2.2
B-1	2	1	2	1	1	7	1.4
B-2	4	4	2	4	1	15	3.2
B-3 *	3	1	1	1	1	7	1.4
B-4 *	3	4	2	1	1	11	2.2
C-1	3	1	1	1	1	7	1.4
C-2	3	4	1	1	1	10	2.0
D-1 *	2	5	3	1	1	12	2.4
D-2 *	1	3	3	1	2	10	2.0
D-3	3	4	1	1	1	10	2.0
E-1	2	4	1	1	1	10	2.0
E-2	3	4	1	5	2	15	3.0
E-3	3	5	1	5	5	19	3.8
F-1 *	3	5	5	1	1	15	3.0
F-2 *	3	5	3	1	1	13	2.6
G-1 *	1	3	2	1	4	11	2.2
G-2 *	3	5	3	3	2	16	3.2

to 3.8 and demonstrated less than acceptable levels of compliance with the documentation criteria standard.

The highest visit average score achieved on the NVDN was 1.4 for visits B-1, B-3, and C-1 which indicated the most compliance with the documentation criteria standard. The lowest visit average score achieved on the NVDN was 3.8 for visit E-3. This score indicates the least compliance with the documentation criteria standard. The average overall visit score for all of the visits in the sample was 2.1.

Analysis of the individual documentation criteria indicated the most compliance with the standard demonstrated on the NVDN was for the criteria of systematic organization (SYST-ORG). The sample's average derived score for SYST-ORG was 1.6. The least compliance with the standard demonstrated on the NVDN was for the criteria of comprehensiveness of documentation of client or caregiver response (COMP-CCR). The sample's average derived score for COMP-CCR was 3.7. In between these extremes in the sample, the NVDN's average derived score for comprehensiveness of documentation of nursing intervention activities (COMP-NIA) was 2.5. For the criteria of accuracy of the recorded data (ACC-DATA), the sample's average derived score was 2.1. For the criteria of accuracy of identification of visit foci (ACC-FOC), the sample's average derived score was 1.8.

The visit average scores for the visits in which the nurse was the case manager were compared with the average scores for the visits in which the nurse was not the case manager. The difference was not important.

Table 7 on page 82 shows the RNs' overall average documentation scores compared with their demographic data. The average documentation scores of the RNs ranged from 1.70 to 2.93. The primary demographic aspects for each RN (age, years of experience in home health, education, and full- or part-time status) were examined for possible factors to further investigate, but no consistency or trends were demonstrated. However, additional demographic information indicated that the two nurses with highest derived scores had experience with the tasks of assisting with chart audits and the monthly review of charts for claims billing in their respective agencies. No other nurses in the sample had noted this type of information on the Nurse Participant Demographic Data Questionnaire.

Table 7

Derived Scores for Documentation and Demographic Data

RN	Overall Average Derived Score	Nursing Education Degree	Years in Home Health	Work Status
A	2.25	AD	1 yr	full time
B	2.05	AD	1-2/3 yr	part time
C	1.70	Diploma	1-1/2 yr	part time
D	2.13	BSN	1/3 yr	full time
E	2.93	BSN	2/3 yr	full time
F	2.80	AD	2-1/2 yr	full time
G	2.70	BSN	4 yr	part time

Chapter 5

CONCLUSIONS AND RECOMMENDATIONS

This chapter presents the conclusions of this investigative field research concerning the documentation of home visits to clients by home health care nurses. Recommendations are made for further study of documentation of home health nursing practice and for use of the tools developed. Implications for the education and supervision of home health care nurses are discussed.

Conclusions

This field research about home health care nursing practice was undertaken to examine the documentation process for client home visits. It is a beginning attempt to identify existing components, parameters, and possible variables that affect the process of documentation of the home health care visit. It is an effort to answer the research questions posed about how home health nurses manage this task of documentation. The conclusions are general in nature and are limited in application. A number of assumptions have emerged, some of which could be developed into tentative research questions for further studies.

The first research question, "What characteristics must be evident for the visit note to (a) document adequately for reimbursement purposes...?", was answered by the results of the literary search and by direct observation of the

documentation process in practice. It was determined that appropriate documentation of home visits is based primarily on criteria required by the fiscal intermediaries dispensing the Health Care Financing Administration's (HCFA) funds to Medicare healthcare providers. Medical records submitted with claims are screened and often scrutinized for evidence of compliance with regulations. Reimbursement for the claims of a home health care provider which were submitted months earlier can be denied on the basis of initial screening or on the basis of the later scrutiny of additional medical records requested. These additional records are primarily the progress notes made by the health care providers, including the nurse's visit documentation notes.

Based on analysis of the rationale of these fiscal intermediaries for reimbursement denials, a body of information about documentation for reimbursement has been gathered. This body of information has become the primary directive for the appropriate documentation of home health nursing services. Quality assurance requirements as well as guidelines to ensure compliance with state and federal regulations have been added to the aforementioned directives for appropriate documentation.

Professional requirements for this documentation, such as the American Nurses' Association's Standards of Home

Health Nursing Practice (1986), reflect current knowledge and practice and have been written within the framework of the nursing process. As such, these standards also have incorporated the requirements of HCFA and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) into the criteria for the standards. These criteria exist to effectively guide professional nursing practice for the improvement of the quality of home health nursing care provided to consumers.

The ultimate power to deny reimbursement for services, however, remains the most potent dictator of what is perceived as appropriate documentation of services. Documentation for reimbursement guidelines continues to determine the priorities for appropriate home health care nursing documentation.

Thus, the agencies in this study had devised specific forms to assist home health care nurses in the documentation of their daily home visits in a manner that assures adequate reimbursement. When questioned about the rationale for the design of the forms, supervisors responded that the format served to cue the nurse to focus on a standard set of comprehensive, pertinent data required for each visit. These formats required specific information, such as, (a) a systematic assessment of the client's body and/or functional systems, (b) the date of next physician's

appointment, (c) the current reason for the client being "homebound," and (d) the nurse's plans for next visit. The checklists and column formats also served to streamline the documentation process as well as to effectively organize the data for easy retrieval by anyone reviewing the record.

The second half of the first research question, "What characteristics must be evident for the visit note to . . . (b) document adequately for purposes of compliance with professional standards?", was answered by the quantitative analysis of coded data from the NVDN to determine the amount of compliance with five criteria of home health care nursing documentation standards.

Prior to discussing these findings, it is important to note that a major limitation of this study was the use of only the researcher's observations as the standard of reference to which the home health care nurses' documentation was compared for degree of compliance with documentation criteria. The researcher's personal preferences and frame of reference are possible sources of bias. Treece and Treece (1977) state that the "independent observations of two trained observers should agree at least 85% of the time. Less agreement than this or data gathered by one individual can be considered only tentative" (p. 233).

A more objective basis of comparison would be a video tape of the visit which could be later viewed by a pair of trained observers. However, a video would also require more extensive preparation with respect to client consents and issues of client confidentiality. A video camera would also be more obtrusive and interfere more in the area of nurse-client interaction, which in turn could increase the probability of the observation method artificially affecting the outcomes.

Another limitation of this study is that it is also possible that the nurses performed their visits and their documentation differently because they were aware of participating in a research study. The nurses might have performed their nursing intervention activities in a more thorough, careful, and explanatory manner than they would have done if the researcher had not been present. They also might have performed their documentation in a more thoughtful, complete, and organized manner because they knew that a copy of the visit documentation notes was going to be used by the researcher for study. The researcher attempted to minimize any of these possible behavior adjustments by disclosing to the nurses only brief, general explanations about the nature and purpose of the field research.

On initial examination of the nurses' visit documentation notes, the researcher observed that there were

general differences in the ways in which the observed facts of a visit (as recorded by the researcher's observation notes or RON) were documented by the home health care nurses in their visit documentation notes (NVDN). The researcher was able to identify these differences as general tendencies of the NDVN when compared to the RON. These tendencies included: (a) the documentation of fewer specifics and details, (b) the grouping and generalization of data, (c) the use of specific documentation formats in a variety of ways, (d) the minimal amount of documentation of client or caregiver responses, and (e) the "over-documentation" by recording data which were not observed by the researcher. The quantitative analysis was performed to more specifically analyze these general tendencies.

The system for deriving scores for compliance with documentation standards was not objectively conclusive. As explained in Chapter 4, the system served to grossly measure how well the task of documenting the home visits was performed by the nurses (Table 1). The most desired score to attain was a 1 or 2. Undesirable scores of 3, 4, or 5 indicated only partial, minimum, or no compliance with the criteria standard. Of the 20 NVDNs in the sample, only eight achieved a desired visit average score of 2.0 or better to demonstrate acceptable levels of compliance with

the visit documentation criteria: visits A-1, B-1, B-3, C-1, D-2, D-3, and E-4 as displayed in Table 6 on page 79.

The conclusions of qualitative analysis of the five documentation criteria are presented here:

1. Comprehensiveness of the NVDN in recording nursing interventions. The COMP-NIA scores for the 20 visits ranged from 1 to 4, with a sample average of 2.5. Only eight of the 20 visit notes received a desirable score of 1 or 2. Twelve of the NVDN COMP-NIA scores were undesirable scores of 3 or 4. This lack of compliance was due to not reporting some of the occurrences of the visit. For example, one visit documentation omitted that the nurse instructed about activity restrictions. Another example is the omission of the documentation of a client reporting possible side effects of a medication. Even if the documentation was recorded in general terms, reporting less than what occurred consisted of omitting information about one or more of the 17 categories of patient condition or functioning which were observed by the researcher in the RON. In some cases, the researcher's analysis found that the omitted information was not central to the focus of the visit, and perhaps was considered by the home health care nurse to be unnecessary to report. This omission, however, did make the NVDN present less than the total specific picture of the client

which is required by guidelines of documentation for reimbursement.

A nurse's experience in professional practice or value of a holistic approach to nursing practice could be factors affecting this aspect of the quality of the nursing documentation. In the sample, the nurse with the best average score for COMP-NIA was a full-time status nurse who had an AD education and one year's home health care nursing experience. Whether the above factors were involved here is not apparent from the demographic data.

2. Comprehensiveness of the NVDN in recording client and caregiver response. The COMP-CCR scores for the 20 NVDNs ranged from 1 to 5, with a sample average of 3.7, demonstrating the samples' least compliance with the criteria. Only four NVDNs achieved a desirable score of 1 or 2; 16 NVDNs received an undesirable score indicating poor compliance. This lack of reporting occurred repeatedly, either because client responses were not reported, or because all inclusive terms were used to describe multiple client or caregiver responses to interventions. Terms like "response receptive" or "receptive to teaching" were found more often than more specific descriptions such as "client agreed to instructions about foot elevation" or "client was able to verbalize signs and symptoms of hypo- and hyperglycemia."

These occurrences of omitting data, of reporting in less detail, and of generalizing data are most likely due to efforts to expedite the immediate task of completing the paperwork of the day's visits. Also, they are possibly due to a lack of awareness about the importance of client and caregiver responses in the instructional process. Teaching clients is more than just talking to them. The instructional process requires an evaluation of learning, which can only be done via feedback from the learner. Comprehensive documentation of client and caregiver responses is needed to validate the need for re-instruction at future visits.

Generally, the nurses with more home health care experience documented COMP-CCR more completely than did those with less experience. Each of the nurses with the best scores for this criteria had more than one and a half year's experience. But, one of the nurses with undesirable scores in this COMP-CCR criteria had 4 years of home health care nursing experience, which is the most experience of any nurse in the sample.

3. Accuracy of the recorded data in the NVDN. The ACC-DATA scores of the 20 NVDNs ranged from 1 to 5, with a sample average of 2.1 Thirteen of the NVDNs achieved a desirable score of a 1 or 2. The undesirable scores were due to: (a) reporting some facts incorrectly within a

category of reported data, or (b) instances in which a nurse reported behaviors not observed by the researcher. This "over reporting" of behaviors was scored on the compliance scale as an inaccuracy resulting in false compliance, and was found to occur most often when the nurse had case management responsibilities for the client involved. This over reporting could be due to repetition of previously recorded occurrences or could be documentation for purposes of making the record more complete. The researcher found only three instances of the nurse actually reporting a fact incorrectly, which were considered faulty record keeping by the home health care nurse.

In general, scores for differences in this accuracy criteria were not found to be consistent with either a nurse's home health experience or basic nursing education. Individually, the nurses who had the two highest overall average scores for compliance with the ACC-DATA criteria had at least 18 months of experience in home health care nursing.

4. Accuracy of the NVDN in the identification of important aspects or foci of the client visit. The ACC-FOC scores for the 20 NVDNs also ranged from 1 to 5, with a sample average of 1.8. Fifteen of the NDVNs achieved a desired score of 1 or 2. Undesirable scores were due to instances in which the NVDN did not correctly identify the

client problems or foci of the visit. In the five NVDNs which did not achieve a 1 or 2 score, there were confusing narrative notes which did not allow for easy retrieval of data.

This "stream of consciousness" documentation could be due to jumbled thought processes and/or the diminished ability to think analytically using the nursing process. Individually, the best RN scores for ACC-DATA were not found to be consistent with either the nurse's education, amount of home health care experience, or work status. The researcher believes that the analytical thinking of the nursing process is a learned task which must be practiced consistently in order for it to become the nurse's automatic response when confronted by client data. To what extent that was a factor in this instance was not determined.

5. Systematic organization of the NVDN. The SYST-ORG scores for the NVDN ranged from 1 to 5, with the sample average SYST-ORG score of 1.6. This score demonstrated the most compliance with documentation criteria. Of the 20 NVDNs analyzed, only 2 did not achieve desirable scores of a 1 or 2 for this criteria. This consistency is seen as directly related to the correct use of specific, well-organized forms for the documentation of client visits. When the forms were used incorrectly, the visit data were scattered and less cohesive. Additionally, some forms were

more comprehensive than others; some even included cues to document client or caregiver's responses to nursing interventions.

The quality of being systematic was found to be most evident with three of the nurses who had been in home health nursing more than 18 months. Greater differences in the systematic organization of the NVDN were found with two nurses who had been practicing home health nursing less than a year and, surprisingly, with one nurse who had 4 years' experience. The greater differences in the systematic organization of the data on the NVDN were also related to the lowest derived scores for accuracy (ACC-FOC) in identifying problems or foci of the visit. With the exception of the nurse with 4 years' experience, this finding might lead to the conclusion that the performance discrepancy in the correct use of agency forms and organization of narrative data could be due to a lack of knowledge or experience or both.

The second research question, "How do home health nurses manage this task of documenting each client visit?", was answered by direct observation of the process and by analysis of the recorded data. This research question is more complex and involves a multitude of factors and possible variables. The sample of nurses did not vary widely in their demographic data (e.g., education,

experience, work status, and training) and as such, may not be representative of home health nurses in general.

These home health nurses were similar in the way in which they prepared for a home visit and performed it. They were also similar in the way in which they evaluated the planned nursing care. Generally, the care plan and the client's recent home visits were reviewed to identify pertinent information and client needs or problems for the planned home visit. The client then was called by telephone to arrange a mutually convenient time for the nurse to visit in the client's home. Some initial documentation was observed to take place during the visit, but was completed later that day, either in the car immediately after the home visit or at the nurse's office desk at the end of the day. This practice demonstrates the variable of timeliness which could adversely affect the quality of documentation. How well can a nurse who has made five to seven client visits in one day recall and sort facts in order to document each visit accurately and comprehensively at the end of the day?

The third research question, "What variables or conditions are identified as influencing this process and to what extent?", is answered by the researcher's conclusions to the first two research questions. Possible factors already mentioned which might affect the home health care nurse in the process of documenting daily client visits

include writing ability, workload, knowledge of appropriate teaching methods, a holistic concept of nursing, attention to detail, critical thinking ability, consistent use of the nursing process, and knowledge and use of common documentation strategies. In searching for demographic variables which might also be significant in influencing this process, any observed association between the most desired scores and nursing education degree, home health care nursing experience, and work status may be strictly serendipitous (Table 6).

Of the seven nurses whose NVDN were analyzed and the scores averaged, only one home health care nurse attained an overall average documentation score of 2.0 or less. This nurse had received a diploma nursing education, had 1-1/2 years in home health care nursing, but worked only part-time. The next highest nurse had an overall average score of 2.05. She also worked only part-time, had 1-3/4 years' home health nursing experience, and had received an AD nursing education. Both nurses had at least 1-1/2 years of home health nursing experience, and worked only part-time. The lessened work pressures of being only part-time, coupled with the similar amount of experience in home health care nursing, could point to the factors of experience and time as important in this task of documentation.

The third highest score of 2.13, however, was achieved by a baccalaureate degree prepared nurse who worked full-time but had been in home health nursing only 1/4 year. The liberal arts portion of a baccalaureate education could possibly be an important factor. However, the other part-time status nurse in the sample had 4 years of home health nursing experience and a BSN education. But, she achieved only a 2.70 overall average score for her documentation.

From the results of this basic field research, these factors appear to be important, but did not affect the nurses' overall average scores in any consistent way. Because of the differences in these nurses and the small sample size, the results cannot be generalized. However, it was interesting to note that the two nurses with the best scores indicated that they both had experience with chart audits for claims billing and fiscal intermediary requests in their respective home health care agencies. No other nurses in the sample noted this type of experience in their demographic data questionnaire. This finding leads the researcher to conclude that the experience of systematically and purposefully reviewing the documentation in home health care clients' charts could be very important as a learning experience about the process of home visit documentation.

Recommendations

The process of conducting this field research as a preliminary study of home health visit documentation generated suggestions for future research. These recommendations suggest more specific and definitive research studies of the factors identified:

1. Replicate this study using a videotaped record of the home health nurses' visits. Use the videotape of the actual visit as the standard by which the documentation is measured. This process would lessen observer error and allow for validation of the observations by a second researcher. Having two researchers evaluate the NVDN would provide for validation of the analysis of the NVDN.

2. Replicate this study with a larger sample to include a wider range of home health nurses and a more representative sample. Specific demographic data would provide valid identification of the factors examined in this study (e.g., education, nursing experience, training, and identification of specific responsibilities in the home health care agency). An interesting addition to the background data collected could include questions to explore attitudes about documentation, such as how the "paperwork" is perceived and is prioritized among the nurse's daily tasks.

3. Replicate this study with a larger variety of sample agencies, each using its own documentation forms, to determine which forms produced the most comprehensive, accurate, and systematic documentation.

4. Replicate this study in a classroom setting as an inservice part of an orientation or an inservice on home health visit documentation. Show a videotape of a nurse making a visit, and require participants to document the visit, with or without a specific format. This process would allow for a critique of individual documentation styles for differences in compliance with standard criteria. Subsequent education for improved documentation performance could then be tested via the activity of the documentation of a second videotaped visit.

5. Replicate this study with all nurses in the sample coming from the same agency, using the same form, and score for differences in the standard documentation qualities. This process would serve as an internal audit of task performance, and problems could be analyzed for causes due to knowledge deficits or due to motivation.

6. Expand or generalize this study to investigate additional components of home health documentation, such as the written plan of care, for the analysis of staff performance problems in care plan documentation.

7. Develop a home health care study to investigate Koerner's (1980) suggestions that a nurse's documentation performance is affected by the nurse's workload, perceived available time, and the nurse's general writing ability.

8. Duplicate this study after the researcher has designed a NVDN recording form that would provide an organized system to demonstrate the comprehensiveness and accuracy criteria.

Implications

Due to the limited scope and strictly exploratory nature of this field research, the aforementioned general conclusions have no statistical significance. Rather, they serve to stimulate the following implications for home health nursing practice:

1. Providing a home health care staff nurse with the experience to act as a reviewer of home health care client charts could be an important way to increase the nurse's knowledge and awareness of documentation criteria and strategies. Whether that additional knowledge and awareness would consistently result in better documentation by that staff nurse could be further studied in a performance analysis. How the nurse as an adult learner perceives the importance of documentation skills would depend on how the home health agency administrators included this task on routine performance evaluations of nursing staff.

2. Length of experience in home health care nursing appears to be a more important factor in satisfactory performance of the task of documentation than does the nurse's type of basic nursing education. This finding might imply little need to require a baccalaureate degree in nursing for a home health staff nursing position which does not include complex responsibilities such as client case management.

3. With the use of the Visit Observation Notes and Data Analysis Tool developed by the researcher, a home health nursing supervisor could effectively perform an evaluation of a staff nurse's performance of the task of documenting home visits. Additionally, analysis and scoring using the five criteria could be used to effectively identify areas for improvement and imply target strategies for learning needs.

4. The forms currently used by an agency to document home visits could be re-examined for appropriate structure and content to facilitate the documentation of accurate, comprehensive, and systematic data about nursing services and client responses. Additionally, frequent inspections of client records could easily identify nurses who are completing the forms in an inappropriate manner. Early intervention to re-instruct staff nurses could improve documentation in a specific and relatively simple manner.

5. The supervision and evaluation of a staff nurse's professional performance is important. This field research associates the direct observation of a home health care nurse interacting with clients as a more accurate, valid basis for evaluating performance than a chart audit which reviews the nurse's documentation of that patient care. In general, current quality assurance programs by regulatory bodies and health care providers alike would do well to utilize more concurrent evaluation methods. The direct observation of professional actions and client outcomes presents the most accurate picture in the analysis for quality improvement in professional practice and client care.

6. Using the documentation criteria and analysis methods of this study, an agency could evaluate any NVDN which has resulted in denial of reimbursement for services in the past 2 years. This evaluation would be performed to identify the amount and type of omissions or errors responsible for the denials. An agency could use these findings and the NVDN analysis process to facilitate prevention of omissions and errors in the future and to decrease the number of denials of reimbursement.

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Appendix A

Human Subjects Institutional Review Board

Project Proposal Review

SAN JOSE STATE UNIVERSITY
GRADUATE STUDIES AND RESEARCH

HUMAN SUBJECTS INSTITUTIONAL REVIEW BOARD
PROJECT PROPOSAL REVIEW

I, the undersigned member of the San Jose State University Human Subjects Institutional Review Board, have reviewed the following proposal submitted to the Committee on August 22, 1988 by:

PRINCIPAL INVESTIGATOR: Margaret Wollen-Olsen
PROTOCOL #: 7348 DEPT.: Nursing
PROJECT TITLE: "A STUDY OF VISIT DOCUMENTATION BY HOME HEALTH CARE NURSES."

I recommend the following action (indicate one):

1. Approved for clearance as involving minimal risk to Human Subjects. ☑
2. Approved for clearance with risk to Human Subjects. ☐
3. Approved for clearance when the following conditions are met: ☐

4. Not Approved (return to principal investigator for following reasons): ☐

5. Expedited Review (specify condition[s] that merit expedited review): ☐

Signature of IRB-HS member — Date: 8-23-88

OFFICIAL SIGNING FOR INSTITUTION

Chair, Human Subjects Institutional Review Board — Date: 9/6/88

Serena Stanford, Ph.D.
AAVP for Graduate Studies & Research — Date: 10/3/88

San Jose State University Foundation
One Washington Square
San Jose, CA 95192-0139 (408) 924-1435

Consent form needs to change phone # for Sharon yes and include reference to VP Grad Studies for complaints re rights. 10-3-88

Some form of consent will need to be obtained from client being observed, even if it is only a statement read to them & verbal consent is witnessed by the home health care nurse.

SAN JOSE STATE UNIVERSITY FOUNDATION
Division of Proposal Processing
(408) 924-1435

DATE: Oct. 3, 1988

TO: Margaret Weber-Olsen

FROM: Darwin Swanson

( ) For your Record

( ) Please sign and return to Foundation

REMARKS Congratulations!
You have received
the final approval
on your proposal.
Attached is a copy
of the final approval
for your
personal record.

****

Appendix B

Research Project Authorization Form

Graduate Studies
Department of Nursing
San Jose State University
San Jose, California

RESEARCH PROJECT AUTHORIZATION FORM

Margaret Wollen-Olson, R.N., B.S.N., P.H.N., a graduate student in Master of Science in Nursing studies at San Jose State University, has permission to invite the RNs at this home health care agency

(named) _____

to participate in a field research study concerning the documentation of home visits to clients by staff nurses. I understand that this study will involve the homecare staff RN having the nurse researcher accompany and observe three home visits to our clients. Each visit will be followed by the staff R.N. giving the nurse researcher a copy of the documentation for the visit, with the names of client, nurse, and agency deleted to guarantee confidentiality of information. I further understand that the results of this field research will be shared with this agency upon request, and that the final report of this research will not identify this agency in any way.

_____
Signature of home health agency director/supervisor

_____
Printed name of person signing above

_____
Date

Appendix C

Nurse Agreement to Participate

AGREEMENT TO PARTICIPATE in study concerning home health care nurses' documentation of home visits to clients, research being conducted by:

Margaret Wollen-Olson, R.N., B.S.N., P.H.N.

I have been asked to participate in a research study being conducted by Margaret Wollen-Olson, currently a candidate for the degree of Master of Science in Nursing at San Jose State University.

I understand that this study is an investigation of home health care staff nurses' documentation of home visits.

I understand that I will be asked to allow the researcher to accompany me to observe me making three home visits. Prior to each visit, I will phone each client and notify him/her of the time of my visit and inform them that, with the client's permission, I will be having a nurse researcher observe me during the visit. If the client agrees to having the nurse researcher present, I will then brief the researcher on the client's plan of care and my specific plans for the visit. After the visit is over, I will document the visit as usual according to my agency's procedures. I will then provide the nurse researcher with a photocopy of my documentation, with the client's, nurse's, and agency's name deleted. I will also answer any pertinent questions the nurse researcher asks about the home visits.

I understand that the results of this study may be published, but that any information from this study that can be identified by me will remain confidential and will be disclosed only with my permission or as required by law.

I understand that my participation in this study is entirely voluntary and that I may withdraw from the study at any time. I also understand that any questions about my participation in this study will be answered by Margaret Wollen-Olson, either in person or at home at (408) 272-8652 or work at (408) 259-5000, x2349 or x2545. Any complaints about the procedures may be presented to Nursing Graduate Studies Advisor Dr. Virginia Young, at (408) 924-3163. For questions or complaints about research subjects' rights, or in the event of research related injury, I will contact Serena Stanford, Ph.D., Associate Academic Vice President for Graduate Studies and Research, at (408) 924-2480.

I HAVE READ AND UNDERSTAND THE CONDITIONS OF MY PARTICIPATION IN THIS RESEARCH AND DO AGREE TO TAKE PART.

Signed _____

Print name _____

(Assigned #_____) Date _____

Appendix D

Nurse Participant Demographic Data Questionnaire

NURSE PARTICIPANT DEMOGRAPHIC DATA QUESTIONNAIRE

Please FILL IN, CIRCLE, or CHECK the following questions as appropriate.

Code # _____ (last 4 digits of Soc. Sec. #) Year of birth _____ Sex: male female

Ethnic background: __ Caucasian __ Black __ Hispanic __ Asian
__ Southeast Asian __ Filipino Other: _____

RN license expiration date _____ PHN certificate: yes no

EDUCATIONAL PREPARATION:

Basic: __ Diploma __ Associate Degree __ Baccalaureate Degree

Date completed: (mo/yr) _____ Location: _____

Other academic degree held:
(CHECK as many as appropriate WRITE date completed)

__ Baccalaureate degree in field other than nursing _____
__ Master's in nursing _____
__ Master's in field other than nursing _____
__ Doctorate _____

Specialty certifications held/type _____

Date obtained (mo/yr) _____

PRESENT EMPLOYMENT:

Type of home health care agency/department: (circle as many as apply)

__ profit __ non-profit __ freestanding __ hospital-based

area: __ rural __ urban __ surburban __ independent __ chain

Current status: __ Full-time (40 hrs/wk) __ Part-time (24-39 hrs/wk)
__ less than 24 hrs/wk
__ Permanent __ Temporary __ Other: _____

Years in current staff nurse position: _____

Are you responsible for any additional duties/projects not normally within the scope of staff nurse? yes no

If yes, please explain _____
_____
_____
_____
_____

Length of time at current workplace: ___ <6 mo. ___ 6-11+ mo.

___ 1-3+ yr. ___ 4-6+ yr. ___ 7-9+ yr. ___ 10+ yr.

PREVIOUS WORK EXPERIENCE

(1st most recent, 2nd most recent, 3rd most recent position)

	Type of employment place	Type of position	Area of clinical nursing practice
1st			
2nd			
3rd			

EDUCATIONAL EXPERIENCES RELATED TO HOME HEALTH CARE NURSING AND/OR HOME HEALTH CARE DOCUMENTATION SKILLS

Type	Title	Date (mo/yr)
___ Orientation:		
___ Workshop:		
___ Class:		
___ Inservice:		
___ C.E. Class:		
___ Journal Article:		
___ Book:		

Appendix E

Verbal Consent of Client

CLIENT #_____ RN #_____

VERBAL CONSENT OF CLIENT to be visited by home health nurse accompanied by nurse researcher.

(Nurse researcher will request that the home health nurse read the following statement over the phone to the client at the time the nurse calls the client to arrange the home visit):

"Before I come out to visit you,
Mr./Mrs./Miss _____ (client name), I would like your permission for me to bring along a nurse researcher to come with me into your home during my visit. This nurse would like to observe and take notes of how I perform my nursing services for you. Would that be acceptable to you?" (or "Is that going to be okay with you?") "Fine; thank you for your permission. We will be out to see you soon. Good-bye."

Signed by nurse obtaining/witnessing client's verbal phone consent:

_____

Print name _____

Date _____

Appendix F

Client Data Sheet

DATA SHEET: CLIENT #_____ RN #_____ DATE _____

Pre-visit: Current Plan of Care
Certification pd: _____ to _____ Start of Care _____
Current Week's Visit Frequency: _____

Client's Insurance: Medicare MediCal Private

Above RN is case manager? yes no
If not, how much experience has RN had with client? _____
_____

Other health care services currently participating in client care/
frequency of visits: _____

Client Age _____ Sex _____ Ethnic Background _____

Medical Diagnoses _____
_____

Client Problems _____
_____

Psychosocial Situation _____
_____

Main Goals for Client _____
_____

Discharge Plans _____

For TODAY'S VISIT: Planned Interventions/Problems to be Addressed:
_____
_____
_____
_____

EXPECTED OUTCOME OF TODAY'S VISIT: _____
_____
_____

Post Visit Data

Unexpected Occurrances During Visit: _____
_____
_____
_____

Unplanned Interventions Performed: _____
_____
_____
_____

COMMENTS: _____
_____
_____
_____

Appendix G

Visit Observation Notes Form

VISIT OBSERVATION NOTES

RN#_____ DATE _____ CLIENT # _____

Visit Setting: _____ page _____

	OBSERVATION/ASSESSMENT Intervention/Response		"HANDS-ON" Intervention/Response		TEACHING/SUPERVISION Intervention/Response		OTHER Type Intervention/Response

KEY: Types of Notes Recorded

OM = Observation of Nurse

OR = Observation of Client/Caregiver Response

MN = Methodological Note (Instruction, Reminder, Critique)

TN = Theoretical Note (Interpretation, Analysis)

PN = Personal Note (Reflection)

Appendix H

Data Analysis Tool

Visit Date:_____ Nurse #_____ Patient:_____ Analysis Date _____

SYSTEMS CLASSIFICATIONS OF DATA: BIOPHYSICAL/FUNCTIONAL	OBSERVATION /ASSESSMENT		HANDS-ON TASKS		TEACHING/ TRAINING		OTHER	
nurse / client	R obs	N doc	R obs	N doc	R obs	N doc	Robs	Ndoc
EYE/EAR/NOSE/THROAT (EENT)								
NEUROLOGICAL (N)								
CARDIOVASCULAR (C-V)								
RESPIRATORY (R)								
GASTROINTESTINAL (GI)								
GENITOURINARY (GU)								
ENDOCRINE (END)								
MUSCULOSKELETAL (MS)								
INTEGUMENT (I)								
(P-S) PSYCH/SOC.								
(N-H) NUTR/HYDR.								
(P) PAIN/COMF.								
(SL) SLEEP/REST								
(A) ACTIV.LEVEL								
(M) MEDICATIONS								
(SAF) SAFETY								
(HMM) HEALTH MNT. MANAGEMENT								
OTHER:								

COMMENTS:_____

Appendix I

Superior Conditions of Teaching and Principles of Learning

3. *There Are Superior Conditions of Learning and Principles of Teaching*

It is becoming increasingly clear from the growing body of knowledge about the processes of adult learning that there are certain conditions of learning that are more conducive to growth and development than others. These superior conditions seem to be produced by practices in the learning-teaching transaction that adhere to certain superior principles of teaching as identified below:

CONDITIONS OF LEARNING	PRINCIPLES OF TEACHING
The learners feel a need to learn.	1. The teacher exposes students to new possibilities for self-fulfillment. 2. The teacher helps each student clarify his own aspirations for improved behavior. 3. The teacher helps each student diagnose the gap between his aspiration and his present level of performance. 4. The teacher helps the students identify the life problems they experience because of the gaps in their personal equipment.
The learning environment is characterized by physical comfort, mutual trust and respect, mutual helpfulness, freedom of expression, and acceptance of differences.	5. The teacher provides physical conditions that are comfortable (as to seating, smoking, temperature, ventilation, lighting, decoration) and conducive to interaction (preferably, no person sitting behind another person). 6. The teacher accepts each student as a person of worth and respects his feelings and ideas. 7. The teacher seeks to build relationships of mutual trust and helpfulness among the students by encouraging cooperative activities and refraining from inducing competitiveness and judgmentalness. 8. The teacher exposes his own feelings and contributes his resources as a co-learner in the spirit of mutual inquiry.
The learners perceive the goals of a learning experience to be their goals.	9. The teacher involves the students in a mutual process of formulating learning objectives in which the needs of the students, of the institution, of the teacher, of the subject matter, and of the society are taken into account.

The learners accept a share of the responsibility for planning and operating a learning experience, and therefore have a feeling of commitment toward it.	10. The teacher shares his thinking about options available in the designing of learning experiences and the selection of materials and methods and involves the students in deciding among these options jointly.
The learners participate actively in the learning process.	11. The teacher helps the students to organize themselves (project groups, learning-teaching teams, independent study, etc.) to share responsibility in the process of mutual inquiry.
The learning process is related to and makes use of the experience of the learners.	12. The teacher helps the students exploit their own experiences as resources for learning through the use of such techniques as discussion, role playing, case method, etc. 13. The teacher gears the presentation of his own resources to the levels of experience of his particular students. 14. The teacher helps the students to apply new learnings to their experience, and thus to make the learnings more meaningful and integrated.
The learners have a sense of progress toward their goals.	15. The teacher involves the students in developing mutually acceptable criteria and methods for measuring progress toward the learning objectives. 16. The teacher helps the students develop and apply procedures for self-evaluation according to these criteria.

From Knowles, M. S. (1970). *The modern practice of adult education–androgogy versus pedagogy*. New York: Association Press.

Appendix J

Standard II of Community

Health Nursing Practice

Standard II. Data Collection

THE NURSE SYSTEMATICALLY COLLECTS DATA THAT ARE COMPREHENSIVE AND ACCURATE.

Rationale

Data collection is essential to a realistic assessment of the community, family, and individual. The process must be comprehensive, accurate, systematic, and continual to allow the community health nurse to reach sound conclusions and plan for appropriate interventions.

Structure Criteria

1. A data collection method is used in the setting; the method provides for—
   a. systematic and complete collection of data.
   b. frequent updating of records.
   c. retrievability of data from the record-keeping system.
   d. confidentiality when appropriate.
2. The practice setting allows access to data on the community, family, and individual.
3. A record-keeping system based on the nursing process is used in the setting; the system provides for concise, comprehensive, accurate, and continual recording.
4. The practice setting has in place a logical system of data collection and retrieval that allows priorities to be set for service to communities, families, and individuals.

Process Criteria

COMMUNITY

The nurse generalist—

1. in collaboration with the specialist and in partnership with the community, collects community data, including but not limited to community resources, power structures, vital statistics, demographics, community dynamics, and socioeconomic, cultural, and environmental characteristics.
2. uses data sources such as legal documents, vital statistics, census data, other public documents, analysis of and by agencies, community contacts, and observations.
3. records data in a standardized, systematic, and concise form.

In addition to the above, the nurse specialist—

1. plans, implements, and evaluates data collection, using advanced methodologies such as surveys, sampling techniques, and instrument construction.
2. uses principles of epidemiology, demography, and biometry, and relevant social, behavioral, and physical sciences to structure data collections.

FAMILY AND INDIVIDUAL

The nurse generalist—

1. in partnership with the family and individual, collects health-related data in the following areas:
   a. health histories.
   b. physical assessment.
   c. growth and development.

d. mental and emotional status.
e. family dynamics.
f. economic, environmental, legal, and political factors affecting health.
g. cultural and religious factors affecting health.
h. knowledge, satisfaction, and motivation regarding health.
i. strengths that maintain and promote health.
j. risk factors that affect health.

2. records data in a timely, standardized, systematic, and concise form.

In addition to the above, the nurse specialist—

1. designs, manages, and evaluates the data collection system.
2. serves as a consultant to the nurse generalist in implementation of the data collection system.

Outcome Criteria

1. The community, family, and individual participate in the data collection process.
2. The data are synthesized and recorded in a standardized and retrievable form.
3. The data are accurate and current.

From American Nurses' Association. (1986). *Standards of community health nursing practice.* Kansas City: American Nurses' Association.

Appendix K

Standard III of Home Health

Nursing Practice

Standard III. Data Collection

THE NURSE CONTINUOUSLY COLLECTS AND RECORDS DATA THAT ARE COMPREHENSIVE, ACCURATE, AND SYSTEMATIC.

Rationale

Data collection is an essential prerequisite to the assessment of the individual, family, and community. The process allows the nurse to reach sound conclusions and plan interventions based in both scientific and social theories. Data collection reflects reality and is the basis upon which the nurse repeatedly evaluates care.

Structure Criteria

1. The organization has a nursing information system that permits the following:
   a. Systematic and thorough data collection.
   b. Simple, accessible, and complete retrieval.
   c. Confidentiality.
   d. Setting of priorities for services to individuals and families.
   e. Collection of aggregate demographic data.
2. A record-keeping system provides for concise, comprehensive, accurate, and continuous recording.
3. The practice setting permits the nurse access to records of assigned clients in a timely manner.

Process Criteria

The nurse generalist—

1. Collects and records data in a standardized, systematic, and concise form.
2. In conjunction with the family and individual, collects data in the following areas:
   a. Health history.
   b. Physical assessment.
   c. Growth and development.
   d. Mental and emotional status.
   e. Family dynamics.
   f. Economic, environmental, and community factors affecting health.
   g. Cultural and religious factors affecting health.
   h. Knowledge, satisfaction, and motivation affecting health.
   i. Strengths that promote and maintain health.
   j. Risk factors affecting health.
   k. Receptivity to health care.
   l. Client and family expectations.
3. Conducts or participates in an ongoing interdisciplinary process of revising and reviewing the data base on the individual and family.
4. Communicates appropriate data to other persons involved in the individual's or family's care.
5. Participates in the design of the nursing information system.

In addition, the nurse specialist—

1. Performs assessment and records data for a select group of individuals and families who require the advanced assessment skills the specialist is able to provide.
2. Designs and manages the nursing information system.

3. Serves as a consultant to and educator of the nurse generalist in implementation of the nursing information system.

Outcome Criteria

1. Nursing information is synthesized and recorded in a standardized and retrievable format.
2. The data base is kept current and accurately reflects the individual's or family's present clinical status.
3. The data base is complete.

From American Nurses' Association. (1986). *Standards of home health nursing practice.* Kansas City: American Nurses' Association.