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A National Framework for District Nurses' Uniform Documentation Patient Records

I. Rising[a], M. Ehnfors[b], L. Abrahamsson[c], A. Borgström[d], B.-M. Forsgren[e] and S. Hellström[f]
[a]Centre for Medical Informatics in General Practice, Sollentuna, [b]Department of Caring Sciences, Örebro University, Örebro, [c]GHSV Härlanda-Öster, Göteborg, [d]Kvarnsveden Health Care Centre, Borlänge, [e]District Nurse Department Askim and [f]Viksjö Health Care Centre, Järfälla, Sweden

Introduction

District nurses in three regions of Sweden have been engaged in local working groups to develop a common and uniform model of documentation which should facilitate and support the district nurses' recording in patient records. The aim is to make documentation easy to handle in the daily work of the district nurse and to secure the input of the correct data needed for continuous quality improvement and reporting. The project is based on the so-called VIPS model (an acronym formed from the initial letters of the Swedish words for well-being, integrity, prevention and safety) [1, 2]. The result of this project to further develop the VIPS model in the area of primary health care will, it is hoped, help the district nurses toproduce a documentation that is more useful and better for patient care and security.

Background

The Medical Record Act of 1986 obliged all registered medical staff to document patient care[3]. Ten years later, several studies show that district nurses in general have not developed routines for the documentation of their work. But there has been some progress. A Swedish model for documentation, the VIPS model, has been introduced by health-care researchers [1,2]. In general terms the VIPS model aims to facilitate a nursing record system that deals with concepts such as the well-being of the patient, securing the integrity of the patient, emphasising the preventive aspects of nursing care and finally is common to all nurses in Sweden. With the use of a uniform model of documentation, mistakes due to different interpretations of the recording are avoided. During their work on the VIPS -model, Ehnfors and her co-workers developed keywords for documentation classified according to the different stages in the nursing-care process [1, 2]. The VIPS-model was very well received by Swedish nurses and has also attracted international attention. So far it has been adopted mainly in institutional care, although one study showed that it could be used by district nurses[4]. However, in order to assist the district nurses' documentation work the VIPS model should be extended to encompass the total field of activity and to define the essential areas of district nursing.

For primary care, further development and a certain adaptation to the special tasks of the district nurse are required since the needs and problems met with and treated by the district nurse in her daily work are not very well described in national studies. In the international literature there are some reports on classification work especially in the home-health care area [5, 6]. The effects of the district nurses' work are not very well known either, but well-structured, and preferably computerised records may in the long run increase our knowledge.

Nursing records with well-documented assessments, diagnoses, interventions and outcomes are a prerequisite for effective quality assurance. The data necessary for quality follow-up are, as a routine, often registered within the framework of medical records, for example, data of patient administration as well as of medical treatment and nursing care. Recurring reports can be made of a patient's visits, illness, treatments and the results achieved, and quality indicators for the nursing care may also be checked as a matter of routine [7]. Expressions and terms reflecting the district nurse's daily nursing care and public-health work are necessary. Furthermore, they should be uniform so as to facilitate co-operation with other public health authorities. These terms should reflect the field of action and be structured and defined in such a way that they enable the nursing care to be followed up. Uniform terms must also be defined and used to enable evaluations, work reports and comparisons to be made [1]. The regulations on quality assurance issued by the National Swedish Board of Health and Welfare clearly state that data for quality assurance should be collected from patient records.

Information technology incorporating computerised patient records can facilitate and support the nursing care of the patient. It also offers other possibilities of creating new methods in nursing routines. In order to optimise the use of computerised documentation, a common language and—very important—a common keyword system must be established [1]. Such a system could also help to overcome information problems between different units and different levels of medical care. Patient records in primary health care are now, to a large extent, computerised. Several record systems are in use, but district nurses' records have been given little attention in these systems.

It is of great importance that the recommendations from this present study for uniform keywords for district nurses' records, presented by the regional working groups, should be accepted for use in most computerised, district-nursing record systems. In the preparatory work for this project a number of goals and requirements have been formulated, such as the following:

- There should be common and uniform terms or keywords with uniform definitions,
- They should be in accordance with the nursing-care process and use the experience gained in the work on the VIPS-model,
- It should be possible to improve and develop them,
- They should function in all computerised and non-computerised documentation and record systems,
- They should describe the district nurses' work in preventive health care,
- They should include essential expressions and terms needed in home care,
- They should correspond to the work carried out at the district nurse's surgery,
- It should be possible to use them also for telephone consultations,
- It should be possible to use them for patient reports in primary health care, as well as in other fields of nursing care,
- They should meet the legal requirements connected with drug prescriptions,
- They should facilitate the follow-up of prescriptions of devices and aids,
- They should be adaptable to all kinds of primary health care, irrespective of the authority responsible

Method

A systematic survey, including several different stages, has been conducted by district nurses divided into working groups in three different regions of Sweden. The task has been to explore and analyse nursing interventions in relation to patients made by the district nurse, both assessments and actions, and also to review the content of patient records to find out how

the district nurse documents her work. All the nurses involved in the three groups have collected all the assessments and interventions made during a two-week period of work. Analyses of the collected data have resulted in enough information to enable suggestions to be made for subdivisions of the keywords of the VIPS -model regarding nursing status and nursing interventions in primary health care.

The second step has been to carry out a number of seminars in which district nurses from the three different regions took part and in which the experience of using the subdivisions of the keywords in both computerised and uncomputerised systems was discussed. The result that emerged from the seminars formed a platform for agreement on the subdivisions of the keywords. The third step will be to use the documentation model with the extended keywords in nursing practice, both in the groups involved and later in a larger test.

Results

The present study is still in progress and therefore there is not, as yet, any result to report. The ultimate aim of the study is to further develop the VIPS -model and to introduce a uniform documentation for Swedish district nurses called the PRIM-VIPS model (from Primary Health Care-VIPS). The type of working process used to promote the implementation of the findings —the work of practising district nurses—was used throughout the studies and this ment that they implemented and tested the model in their own work. The model was then tested and implemented step by step and the new part is included in the basic VIPS model. The requirements established for further development of the model are met to a large extent as well as the demands from the field of work of district nurses which has been investigated. Computerised record systems based on uniform keywords will give continuous output as a base for follow-up development of care and quality assurance.

References

1. Ehnfors M, Thorell-Ekstrand I, Ehrenberg A. Towards basic nursing information in patient records. *Vård i norden* 1991;(3/4):12-31.
2. Ehrenberg A, Ehnfors M, Thorell-Ekstrand I. Nursing documentation in patient records: experience of the use of the VIPS model. *J Adv Nurs* 1996;24:853-867.
3. Svensk författningssamling. SFS. *Lag om patientjournal.* (Swedish Medical Record Act). 1985:562
4. Ehnfors M, Nordstrand K. Distriktsskšterskans patientrelaterade omvårdnadsarbete. *Socialmedicinsk tidskrift* 1995;(4-5):177-183.
5. Saba VK. The Classification of Home Health Care Nursing Diagnoses and Interventions. *Caring* 1992;10(3):50-57.
6. Martin KS, Scheet NJ. The Omaha System: Applications for Community Health Nursing. Philadelphia, WB Saunders Co, 1992.
7. Linnarsson R. Methods ,design and components for a computer-based patient record to promote quality care in general practice, Linköping University Medical Dissertations, 1993, (no378.).