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Improving the Documentation of Patient Progress in a Mental Health Facility Through the Use of Training and Feedback

Maria Sonia Acosta
Western Michigan University

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**IMPROVING THE DOCUMENTATION OF PATIENT PROGRESS
IN A MENTAL HEALTH FACILITY THROUGH THE USE OF
TRAINING AND FEEDBACK**

by

Maria Sonia Acosta

**A Dissertation
Submitted to the
Faculty of The Graduate College
in partial fulfillment of the
requirements for the
Degree of Doctor of Philosophy
Department of Psychology**

**Western Michigan University
Kalamazoo, Michigan
December 1990**

**IMPROVING THE DOCUMENTATION OF PATIENT PROGRESS
IN A MENTAL HEALTH FACILITY THROUGH THE USE OF
TRAINING AND FEEDBACK**

Maria Sonia Acosta, Ph.D.

Western Michigan University, 1990

The purpose of the present study was to evaluate the effectiveness of various conditions, including staff training and feedback to improve the documentation of patient progress in a mental health facility. Forty nursing staff members participated in this study. Subjects were exposed to one of three experimental conditions. Subjects in the training-only condition received two hours of training on how to write progress notes. Subjects in the training plus feedback condition received two hours of training and weekly feedback in the form of group performance graphs and verbal explanation of their progress. Subjects in the third condition served merely as a control group. Results indicate that the progress notes written by the staff in the training-plus-feedback condition showed the most consistent improvement.

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DEDICATION

**I would like to dedicate this dissertation to my parents, Cecilia and Miguel,
who have always been supportive and understanding.**

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I would like to thank my committee members, Dr. Paul Mountjoy, Dr. Jack Michael, Dr. Thelma Urbick, and especially Dr. Dale Brethower, for their advice, guidance, and understanding. Special thanks are in order to Lenore Sauer, Director of Nursing at Kalamazoo Regional Psychiatric Hospital (KRPH), for believing in me and supporting this project.

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Maria Sonia Acosta

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CHAPTER I

INTRODUCTION

The Department of Mental Health for the state of Michigan requires documentation of treatment delivery and evaluation of the impact of that treatment on the recipients of mental health services (Pratt, 1988). These requirements include the implementation of quality assurance programs that examine the types of treatment provided to recipients of services, the evaluation of the impact that these treatments have on the recipients, the implementation of training programs for care providers, and the demonstration that training costs are justified.

Organizational behavior management techniques can help meet these requirements. This systematic approach to managing human performance provides the necessary tools to assess, develop, implement, and evaluate the quality of services provided by an organization (Frederiksen, 1984; Pratt, 1988; Riley & Frederiksen, 1984). Organizational behavior management technology can aid in the effective implementation of programs directed to evaluate services and improve productivity (Quilitch, 1975; Rathjen, 1984; Rice & Lutzker, 1982).

The current study is concerned with improving the documentation of patients' progress through the use of training and feedback. The intended outcome is to help staff meet progress notes standards with the long-range goal

of better utilizing progress notes in deciding whether patients need further hospitalization or may be discharged.

Now, let us turn to the important elements of this analysis: medical records, progress notes, nursing staff, staff training, and the role of feedback.

The Medical Record

All significant clinical information pertaining to a hospitalized patient is incorporated into the patient's medical record (Joint Commission on Accreditation of Hospitals Organizations [JCAHO]; 1983). Every patient's record must include an individualized treatment plan that reflects what the hospital staff does in caring for the patient; the plan is based upon the reasons for admission and hospitalization. Implementation of the treatment plan is monitored by an interdisciplinary team comprised of a psychiatrist, registered nurse, social worker, psychologist, activity therapist, and residential care aide. Regular progress notes are entered into the patient record and modifications in the treatment plan are made according to progress (Kalamazoo Regional Psychiatric Hospital [KRPH], 1988).

According to the Joint Commission on Accreditation of Hospital Organizations (1986), the purposes of the medical record are to:

1. Serve as a basis for planning patient care and for continuity in the evaluation of the patient's condition and treatment.
2. Furnish documentary evidence of the course of the patient's medical evaluation, treatment and change in condition during the hospital stay, during an

ambulatory care or emergency visit to the hospital.

3. Document communication between the practitioner responsible for the patient and any other health care professional who contributes to the patient's care.

4. Assist in protecting the legal interest of the patient, the hospital, and the practitioner responsible for the patient.

5. Provide data for use in continuing education and research.

The record should be sufficiently detailed to enable the practitioner to give effective continuing care to the patient as well as to determine what procedures were performed and what the outcome was. Some of the criteria for good documentation are objective information, timely documentation, legible writing, and use of approved abbreviations.

Progress Notes

Progress notes must provide a pertinent chronological report of the patient's course in the hospital, reflect any changes in physical and mental condition, and describe the outcome of treatment (JCAHO, 1986).

The following standards must be met:

1. Notes must be written in descriptive rather than interpretive terms, that is, behaviors should be observable and measurable (Health Care Finance Administration [HCFA], 1986; JCAHO, 1983).

2. Notes must be related to the patient's treatment plan (JCAHO, 1983).

3. Notes must describe actions taken by staff when dealing with the patient

(Bloom, Dressler, Kenny, & Pardee, 1971; JCAHO, 1983).

4. Notes must include the patient's response to staff interventions (HCFA, 1986; JCAHO, 1983).

5. Notes must be dated and signed including first initial, last name, and professional title or discipline (HCFA, 1986; JCAHO, 1983; KRPH, 1988).

6. Notes must be free of derogatory terms such as "brain-damaged" or "pesty" (Michigan Commission on Handicapper Concerns, 1988).

Written observations such as "Patient slept well" or "No complaints" do not satisfy the requirements for a progress note. Notes must describe how the patient is or is not progressing toward short and long term goals. If lack of progress is indicated, there must be evidence of treatment plan revision.

Progress notes are useful not only as descriptive tools, but they also provide factual information of the patient's progress which is used by psychiatrists and others in court. In addition, progress notes serve the decision-making process relative to continuing hospitalization.

Nursing Staff

Nursing data are a vital part of the medical record. Nursing staff are in a position to assess the patient frequently, to implement the psychiatrist's orders, and to coordinate health services for the patient (Kelly, 1971). Observations by nursing staff must be recorded on a daily basis and must provide a clear picture of the patient's condition, treatment, and course of illness (Bertucci, Huston & Perloff, 1974).

The requirements to develop quality assurance programs and the mandate to provide active treatment in mental health facilities make the development, maintenance, and evaluation of programs essential to meet the need for accountability (HCFA, 1986; Pratt, 1988).

Nurses can no longer be naive about the legal implications of practicing nursing in today's society (Feutz-Harter, 1989). The primary purpose of charting is to record and communicate pertinent information regarding the patient. A second purpose is to obtain reimbursement from the government and insurance companies. Reimbursement is dependent on what is documented in the patient's medical record. The third purpose for documentation is to create a record which can be used in a variety of legal proceedings.

Unfortunately, the patient's record of progress is not always complete and, therefore, does not provide enough information on how the patient is responding to treatment. One of the variables that we could look at is staff skills in writing notes that are clear and descriptive of patients' course of hospitalization. This requires effective staff training programs oriented toward increasing productivity and satisfaction with the outcome produced.

Staff Training

Training is an important component of any program directed toward improving staff knowledge and skills. Staff training can be viewed as a behavior modification program: target behaviors need to be identified, data need to be gathered to determine whether training has altered the target behaviors, the

relationship between training and behavior change needs to be determined, and follow-up data need to be gathered to insure that gains are maintained (Kazdin, 1974).

Training is a process by which the trainer expects to bring about a change in response to a given environment. When such a change has occurred, we say learning has taken place (Folley, 1967). For instance, if we want nursing staff to learn to discriminate between acceptable and unacceptable progress notes, we must present the appropriate stimuli, that is, examples and non-examples of progress notes that meet the standards required (See Appendix C). In addition, we should give staff the opportunity to make the required response during the training sessions to determine whether learning has taken place. It is also important to provide feedback on whether he/she has made the correct response or not. If trainees make an incorrect response, information on specifically what was wrong is more beneficial than the simple statement of "incorrect." Appendix F shows an example of how the feedback graphs looked during this study.

Training is appropriate when there is a real skill or knowledge deficiency (Ross, 1982). In the present study, training was considered necessary to implement a new method of charting in the Nursing Department of Kalamazoo Regional Psychiatric Hospital (KRPH, 1990). This department used the Focus Charting Process developed by Lampe in 1985 (Appendix B). Nursing staff supervisors for all units in the hospital were given a training session that consisted of a 12-minute videotape, a typed example of the focus charting and an opportunity for questions and answers. They were then to go back to their

respective units and share this information. Staff were to watch the videotape and had an opportunity to ask questions about the new charting process.

Instructional procedures which are usually employed tend to have temporary effects on the behavior of staff, just as they do on the patients. Research demonstrates that more permanent effects can be obtained using monitoring and feedback.

The Role of Feedback

Behavior change has been facilitated by feedback intervention strategies designed to provide information and guidance to individuals or groups about the quantity or quality of their performance (Brethower, 1972; Fairbank & Prue, 1982; Gilbert, 1978).

Changes in employee behavior that follow feedback intervention have been attributed to the effects of reinforcement (Duncan & Bruwelheide, 1986; Fairbank & Prue, 1982). There is still some controversy about the differences between feedback and reinforcement but this difference is a historical one (Brethower, 1972). One approach to consider is that feedback, when functioning to guide human performance, is a kind of reinforcement; if it is not, we should try to find other ways to make the feedback reinforcing and, therefore, strengthen behavior.

Feedback can also produce changes in organizational behavior that might contribute to the success of performance systems. One such effect occurs when performance feedback instructs employees in the requirements or standards of their jobs. Another explanation of feedback effects occurs when performance

within an organization is below standard. For example, public posting of percentage of unmet progress notes standards might act as encouragement for employees to improve performance to avoid supervisor's or peers' disapproval. Competition among groups or individuals could also play a significant role in motivating employee behavior change.

A variety of attempts have been made to provide positive reinforcement to staff's performance. These attempts include contingent reinforcement in the form of vacations, workshift preferences, bonuses (Ayllon & Azrin, 1965), and monetary reinforcement (Katz, Johnson & Gelfand, 1972). The specific types of dimensions affecting feedback are numerous, as noted by Ford (1980). These include individual versus group, private versus public, personal versus mechanical, immediate versus delayed, and the schedule of feedback. Other variations of feedback not mentioned by Ford are written and self-recorded feedback (Fairbank & Prue, 1982). However, most institutions do not allow wage bonuses, vacations, and promotions to be administered on the basis of staff performance. Praising staff and providing feedback for performance are possible alternatives, as feedback has been shown to maintain staff performance at high levels (Balcazar, Hopkins & Suarez, 1986; Ivancic, Reid, Iwata, Faw & Page, 1981; Kreitner, Reif & Morris, 1977; Maher, 1982; Prue, Krapfl, Noah, Cannon & Maley, 1980).

Several studies of feedback are of interest here. Panyan, Boozer & Morris (1970) provided staff training in operant conditioning. Staff was instructed to conduct training sessions and to keep daily performance records. The data from the recording sheets were compiled to show the percentage of sessions conducted.

This percentage was then written on a feedback sheet and given to the attendants. The authors found that the weekly delivery and posting of feedback sheets increased the percentage of training sessions conducted by the staff.

Quilitch (1975) investigated the effects of three staff-management procedures to ensure implementation of desired programs. In this study, the administrator of an institution for individuals with mental retardation (1) sent a memorandum instructing all staff to lead daily recreational activities, (2) sponsored a workshop teaching staff to lead such activities, and (3) assigned staff activity leaders and provided performance feedback to staff by publicly posting the daily average number of active residents on each ward. Neither the memorandum nor the workshop caused staff to provide more activities, but after staff were scheduled to lead such activities and given performance feedback, the average daily number of residents engaged in activities increased from seven to 32.

Komaki, Heinzmann, and Lawson (1980) conducted a total of 165 observations on desired safety practices for a vehicle maintenance division. They used a multiple-baseline design with a reversal component in which five conditions were introduced: (1) baseline, (2) training only 1 (safe practices were discussed and posted), (3) training and feedback 1 (supervisors provided feedback about the safety level on graphs), (4) training only 2, and (5) training and feedback 2. Performance increased considerably during the training and feedback phase. The authors concluded that the provision of training alone is not sufficient for improving and maintaining performance.

Jones, Morris, and Barnard (1986) used a multiple baseline design to assess

the effects of an instruction and feedback package on correct completion of civil commitment forms by psychiatric emergency room personnel. The forms were for notices of rights, imminent harm applications, and witness lists. The intervention consisted of a training component and weekly group feedback via graphs. The instruction and feedback package produced immediate and significant increases in correct completion of all forms and the effects were maintained at six months follow-up.

Although interventions which utilize training and feedback have been applied extensively in industrial settings, the study of the combined effects of these variables in mental health institutions has been limited. The present dissertation was a systematic replication of Jones et al. (1986) with the added feature of expanding the study of the effects of training and feedback on staff performance in a mental health facility. The performance of nursing staff was studied under conditions of training alone and then training combined with feedback.

Before the implementation of this study, Brethower's Total Performance System (1972, 1982) was used to analyze the systems involved in this study. It is called that because it includes a wide variety of adaptive system components. These components are inputs, a processing system, processing system feedback, outputs, a receiving system, and receiving system feedback. Figure 1 lists the major inputs, outputs, etc., for this research study in connection with nursing staff progress notes deficiencies. The inputs are things taken into a system to be changed into outputs such as raw materials, human resources, etc. The processing

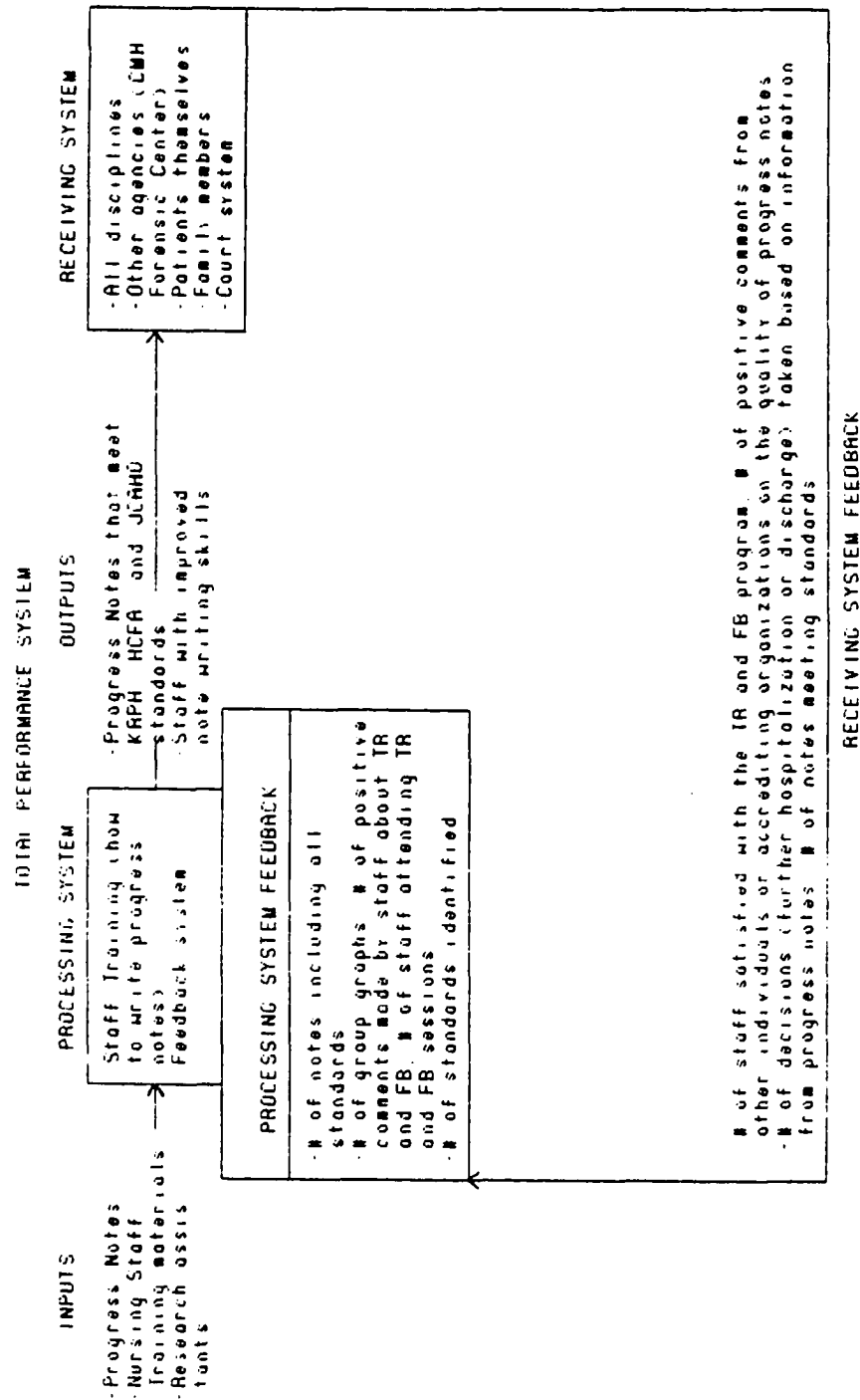


Figure 1. The Total Performance System.

system is a system in which one or more inputs are changed into one or more outputs such as a training program or a feedback system. The outputs are the goods and/or services produced by the receiving system, in this case, the progress notes. The receiving system is the system which receives the outputs of the processing system. Processing system feedback comes from data generated by the performance system which produces the goods and services. Receiving system feedback comes from data generated by the system which receives them.

A goal statement and two of the steps of the system description aid developed by Brethower in 1987 are included in Appendix A.

CHAPTER II

METHOD

Subjects and Setting

The subjects for this study were 40 members of a hospital nursing staff, which included 11 registered nurses, four licensed practical nurses, and 25 residential care aides. All staff worked full time at one of three continuing care units for adult male patients at the Kalamazoo (Michigan) Regional Psychiatric Hospital (KRPH). All regular staff from the morning (7:00 a.m. to 3:00 p.m.) and/or afternoon (3:00 p.m. to 11:00 p.m.) shifts were included. They were responsible for writing progress notes for every patient on a daily basis.

At present, KRPH is operating under a Consent Decree between the Michigan Department of Mental Health and the United States Department of Justice (DOJ) to improve existing conditions, including staff training, professional staff development, and treatment delivery. This study focused on training nursing staff to write progress notes that would meet standards set forth by the Joint Commission on Accreditation of Hospitals Organizations (JCAHO), the Health Care Finance Administration (HCFA), and KRPH Nursing Department. Staff were told that this was a project to evaluate the training now being required for nursing staff at KRPH on writing progress notes. Training was conducted in a small room

on each of the three units.

Procedure

Dependent Variables

The dependent measures were: (a) the percentage of notes written in observable rather than interpretive terms, (b) the percentage of notes related to the patient's treatment plan, (c) the percentage of notes describing the actions taken by staff when dealing with the patient, (d) the percentage of notes describing the patient's response to staff interventions, (e) the percentage of notes dated and signed by the staff members, (f) the percentage of notes containing derogatory terms, and (g) the correct use of the data-action-response format.

The indicators are listed below and further explained in the training manual or workbook (Appendix C).

1. Does the progress note reflect the patient's treatment plan?
2. Are the patient's behaviors described in observable terms?
3. Are actions taken by staff when dealing with the patient described in the note?
4. Is the patient's response to staff intervention described?
5. Is the note dated and signed by staff?
6. Is the note free of derogatory terms?
7. Is the Data-Action-Response format used correctly?

Scoring System

Four student assistants (observers) participated in the scoring of data. Responses were recorded on a score sheet according to the indicators listed above for each standard question as either 1 or 0 (Appendix E). For instance, if a patient's response to staff's intervention was described in the note, then the indicator "Is patient's response to staff intervention described?" was scored "1."

Observers had to use one different scoring sheet for each patient every month. They recorded their own initials on each sheet so that reliability checks could be made at a later time. They started by recording the patient's code, the unit name, the staffs' code, the shift (a.m. or p.m.) and 1 or 0 for each of the standard questions. Those staff who were assigned full time to a specific unit were considered regular staff and were given a specific code. Those staff who worked on the unit every now and then were considered supply staff (code S) and were given this general code. Supply staff were grouped together because all of them had in common that they did not receive any of the experimental conditions of this study. Those staff who worked on one of the three experimental units but who supplied to one of the three units other than their regular unit were considered special supply (code SS). They had in common that they had already received training from the experimenter in their regular unit. To clarify, when a regular staff on unit 1 worked on unit 2 or 3, he/she got a SS code. All these codes were given this way to minimize variability of the data.

Once all patients' sheets were recorded, the experimenter calculated

percentages per shift and per unit on a weekly basis. Data were taken from an average of 14 patients in each unit.

Confidentiality

All identifying information was deleted from copies of the progress notes by a research assistant (not the experimenter) employed by KRPB before the experimenter and student observers came into contact with the progress notes. This included the patients' names and the staff's names. A letter code was assigned to each regular staff and a particular number to each patient. No individual staff data were used. The research assistant also checked for standard question #5, that is, she put an X or a check mark next to the staff code based on whether the progress note included the date, time, first initial, last name, and title or discipline. This coding system allowed for confidentiality of data. She was not further involved in this research project.

Observer Selection and Training

Observers were selected after they expressed an interest in participating in the research while doing a practicum at the KRPB Psychology Department. All were psychology students at Western Michigan University, Kalamazoo.

Training materials were developed using some examples from Menciarelli's (1988) "Treatment Planning and Documentation: Phase II: How to Write Statements in Observable and Measurable Terms", and Phillips, Pullins and Smith's (1985) article "Establishing Functional Behavior Goals for Psychiatric Patients."

The researcher generated examples and non-examples in accordance with existing standards to illustrate each indicator and included them in the training manual (Appendix C).

Training sessions, lasting from two to three hours, were conducted at KRPB by the experimenter. Student observers had to study the training manual and answer the exercises. In addition, they were given flashcards with more examples and non-examples of each standard arranged in random order and were asked to score them as either examples or non-examples of a correctly written progress note.

The research assistant who deleted the identifying information did not need special training. She was instructed to check for the date, time, staff's first initial and last name and title or discipline. Also, she checked for legibility in the signature and gave an X for those signatures that were not readable. She was told that staff codes were changed at the time of reporting the results for confidentiality purposes.

Reliability

The experimenter and one of the four student observers served as reliability observers. A special reliability sheet was utilized (Appendix E) and 25% of the progress notes were scored in a random fashion. Interobserver agreement was computed using a point-by-point agreement ratio (Kazdin, 1982). Agreement was defined as both 1 or both 0. The formula is:

$$\text{Point-by-point agreement} = \frac{A}{A + D} \times 100$$

A= agreements for each indicator/standard

D= disagreements for each indicator/standard

Observers consistently obtained high percentages of agreement throughout the study, averaging 95.5% overall. To minimize the possibility of observer bias, two of the observers were not informed about the timing of the experimental phases.

Informed Consent

Informed consent was not required by the Human Subjects Institutional Review Board (see Appendix G).

Experimental Design

A multiple baseline design across groups (Baer, Wolf, & Risley, 1968) with time of introduction of the conditions varying for the three units was used to assess the effects of training and feedback on the three units. Training (TR) was provided to nursing staff on unit 1, and then, after three weeks, training was provided to staff on unit 2; then, three weeks later, training was provided to staff on unit 3. Training was completed in one unit before going to the next unit.

Feedback (FB) in the form of group graphs and verbal feedback was provided every week after training took place. Feedback was only provided to units 1 and 2. This procedure assisted in the identification of training effects on unit 3 staff's performance. After three months of providing feedback, a follow-up

(FU) condition was in effect in which no feedback was provided to staff on progress notes performance (see Table 1).

Training was provided to the a.m. shift staff on unit 1. They included three registered nurses, one licensed practical nurse, and five residential care aides. Staff in the p.m. shift did not receive training so that later comparisons between shifts could be made on performance.

Training on unit 2 was first provided to the a.m. shift staff which included three registered nurses, one licensed practical nurse and four residential care aides. After one week, training was provided to the p.m. shift staff which included two registered nurses, one licensed practical nurse, and four residential care aides.

Training sessions were completed in about a week for all staff members in each shift. Following the week of training, staff received feedback on progress notes on a weekly basis.

Staff on unit 3 included 5 registered nurses, 1 licensed practical nurse, and 11 residential care aides. The p.m. shift staff received training first followed by the a.m. shift staff a week later.

Conditions

Baseline

Copies of progress notes were scored before implementing any changes in the record system. Baseline data were collected for the month of March (BL 1)

Table 1
Experimental Conditions for Each Unit

Unit	Conditions			
1	BL (12)	TR (a.m. shift)	FB (15)	FU (8)
2	BL (15)	TR (a.m. shift)	FB (13)	FU (7)
	BL (18)	TR (p.m. shift)	FB (11)	FU (6)
3	BL (22)	TR (p.m. shift)	FU (16)	
	BL (23)	TR (a.m. shift)	FU (15)	

Note. BL = Baseline, TR = Training, FU = Follow up

The numbers in parentheses represent the number of weeks.

when staff members were using the narrative style of writing progress notes. An example of this style was:

DATE

PROGRESS NOTES

3-4-90 1330 The patient has been pleasant and cooperative. He ate well, used his ground permit and did his oral care with staff supervision.

In addition, baseline data were collected a second time (BL 2) during the months of April and May when the new focus charting system was implemented by the Nursing Department. An example of this new style was:

DATE

FOCUS

PATIENT CARE NOTES

4-4-90 Threatening DATA: Standing in a fighting 2030 behavior

stance toward staff and making statements of harm toward others.

ACTION: He was instructed to go to another area and stop threatening.

RESPONSE: After repeated directions, Mr. X did comply.

Training

Staff were required to attend two 1-hour training sessions. They used a workbook which described appropriate methods for writing progress notes in accordance with standards. Staff were informed that this was a project designed to improve the quality of progress notes written by staff at KRPH.

The experimenter met with two or three staff members at the same time to go over the training materials. Staff discussed the examples and non-examples for each standard with the experimenter. Then, they performed the exercises provided in the workbook and received feedback on their responses. Training sessions were divided in two one-hour sessions. Staff do not always work every day and training sessions were scheduled for two consecutive working days.

Feedback

Graphs depicting the percentage of successful performance on each progress note standard were posted on units 1 and 2 on a weekly basis. In addition, each staff member of units 1 and 2 received a copy of this graph. Only performance data for a specific unit were posted on that unit. The percentage of each indicator was computed as follows:

$$\% = \frac{\text{Total number of 1 scores for that indicator}}{\text{Total number of progress notes scores}} \times 100$$

Percentage of compliance with the standards was computed and graphs were posted on a weekly basis. Although individual performance was monitored, only group performance was posted.

In addition to these graphs, the researcher met with staff on the same day the graphs were presented. Meetings were conducted with the morning nursing staff between 9:30 a.m. and 11:00 a.m. and at 2:30 p.m. with the afternoon staff for approximately 10 minutes to discuss the graphed data.

Weekly feedback meetings were conducted in which staff members had an opportunity to ask questions concerning progress note standards and the graphs. Feedback was given preferably in a group context but often staff could not be there at the same time. They were given the same verbal feedback as the others either during the next hour, the next day, or during the next three days. They received feedback before they wrote a progress note that week.

Follow-up

After about four months of providing feedback, staff was informed that no additional graphs were to be provided, but the collection of data was to continue. This follow-up condition was in effect for two months.

CHAPTER III

RESULTS

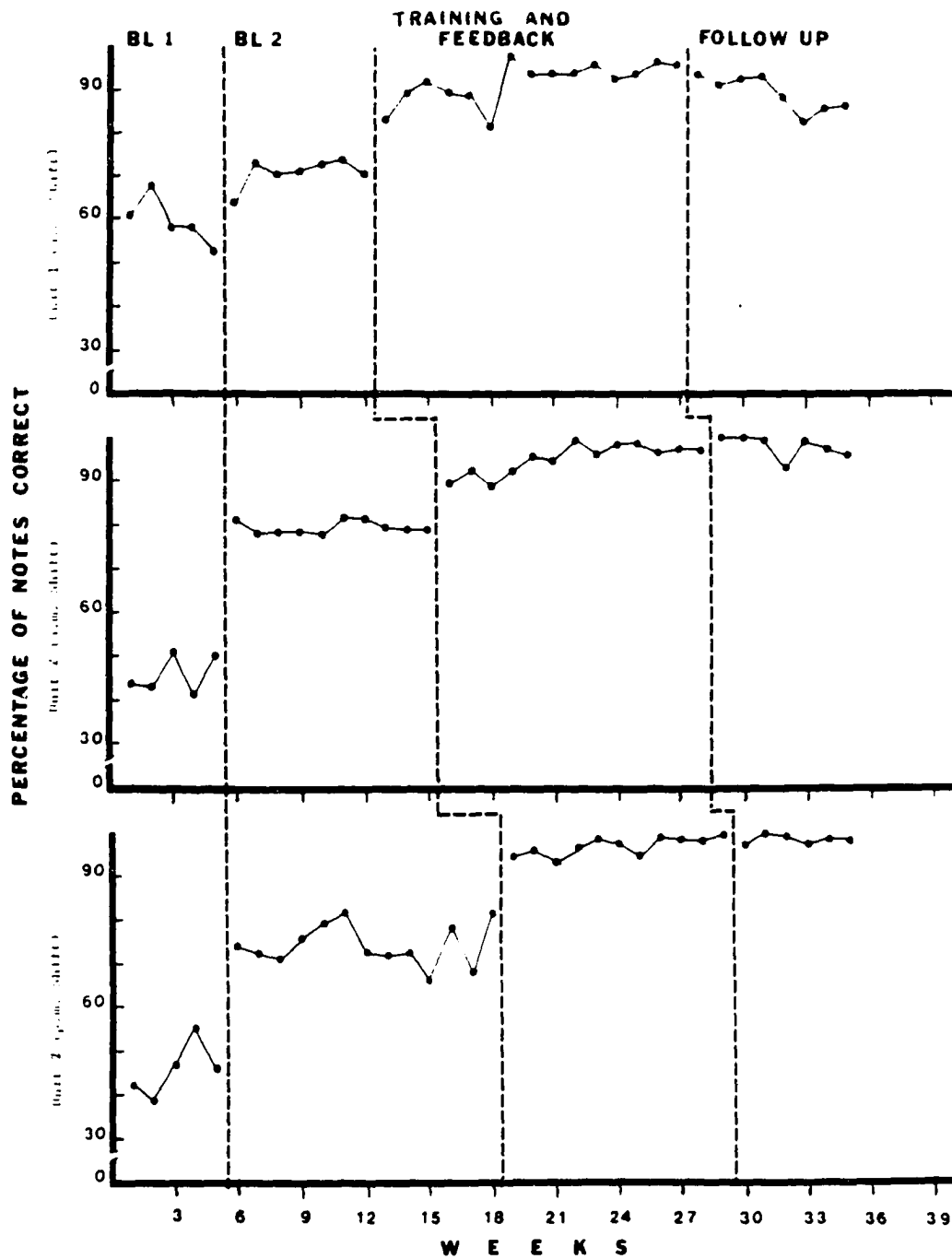
Figure 2 shows the weekly percentage of correct progress notes written by nursing staff on a daily basis. Table 2 presents summary data for the three units during the four experimental conditions.

One subject in unit 1 transferred to a different unit during the last week of the training plus feedback phase; two subjects in unit 2 left their positions 6 and 4 weeks into the training plus feedback phase. Their data to that point have been included in the analyses that follow.

Component Analysis

To determine the relative effectiveness of the components, a visual inspection of the data was made. With the introduction of Focus Charting (baseline 2) by the Nursing Department, progress notes improved significantly with regard to standards in comparison to the narrative style previously used.

Training produced further immediate improvements for both training-only and training plus feedback phases, as the data in Table 2 make clear. Introduction of training in unit 1 produced an increase of 29.78%; improvement in unit 2 was 23.97% and 34.67% in unit 3. Although all three units showed significant improvements, trends in the data for unit 3 suggest that the improvement might



Note. BL = Baseline, T = Training

Figure 2. Percentage of Correct Progress Notes Written in all Units During Each Experimental Condition.

Figure 2--Continued

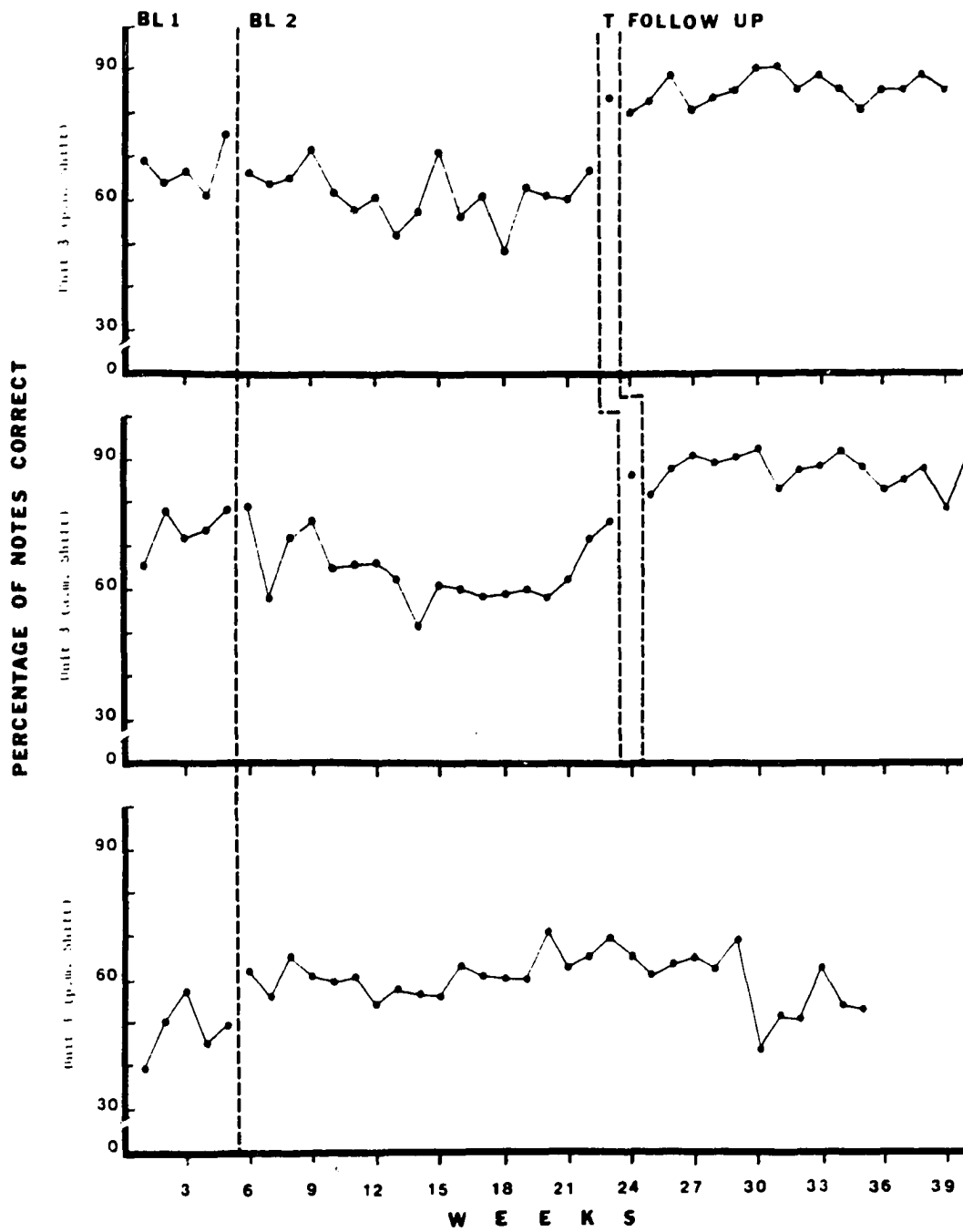


Table 2
Averages for Overall Performance per Unit
for Each Experimental Condition

Experimental conditions	Unit 1		Unit 2		Unit 3	
	a.m.	p.m.	a.m.	p.m.	a.m.	p.m.
BL 1	59.20	48.50	46.08	45.87	73.78	67.48
BL 2	70.87	60.71	79.70	74.66	65.10	61.67
TR only	--	--	--	--	86.48	84.24
TR + FB	91.98	--	94.80	96.32	--	--
Follow-up	88.97	--	97.48	97.75	87.59	86.24
n	9	8	9	6	8	8

Note. BL = Baseline, TR = Training, FB = Feedback

not have been sustained over time.

Performance during the follow-up condition remained fairly constant for the training and feedback group--an average of 94.73%--in comparison to a decrease of 86.91% for the training-only group. Performance in the control group (unit 1 p.m. shift) resulted in virtually no improvement; these staff performed at the 60% level.

There were virtually no differences between shifts with regard to the efficacy of the training-only and the training-plus-feedback conditions. Data analyses were also made by looking at the performance for each progress note standard and for

every individual staff member.

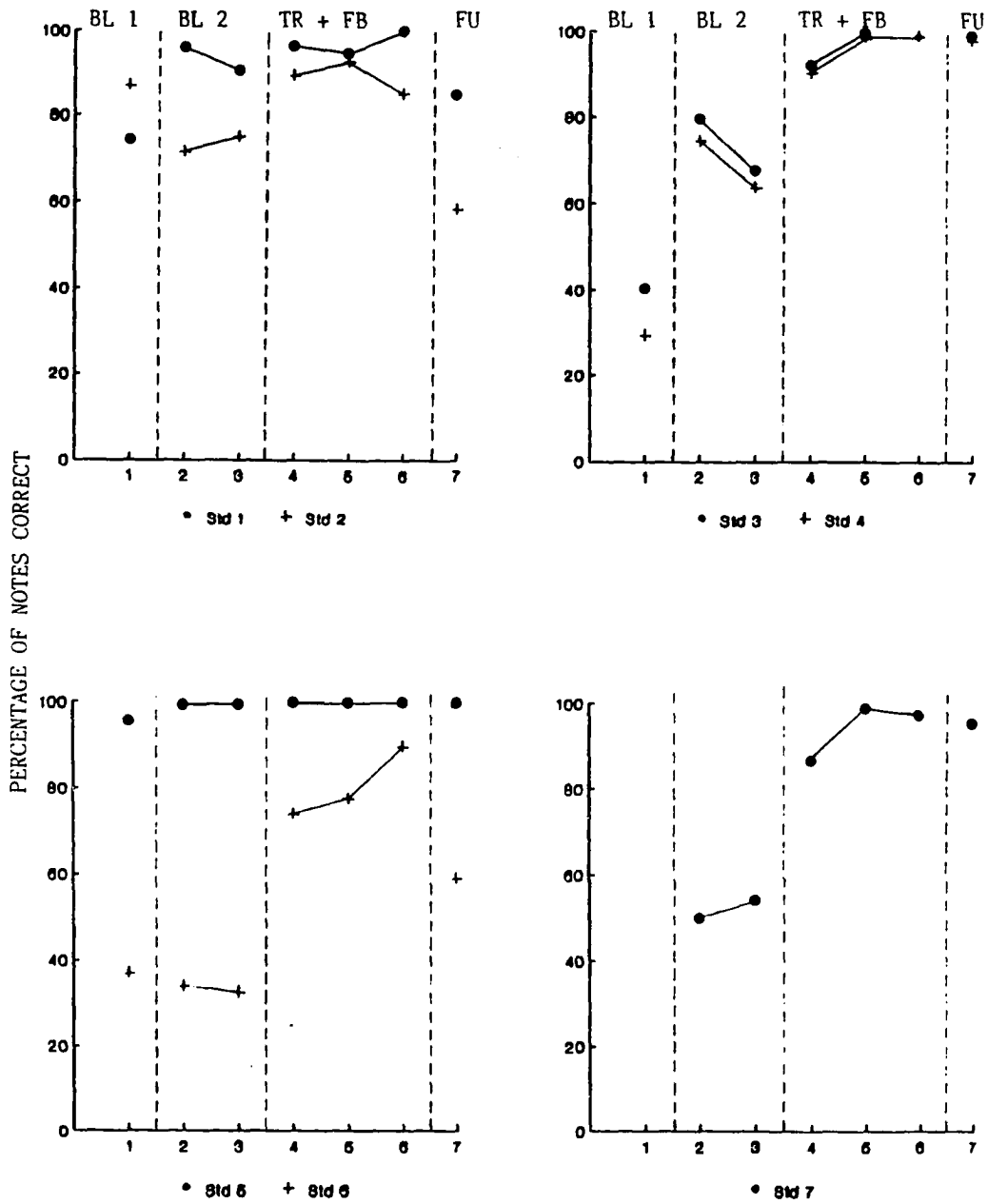
Performance by Standard

Figures 3 and 4 show staff performance on each progress note standard for unit 1. Standard 5 shows the highest scores for both shifts. The second highest scores were for standards 1 and 2. Standards 3 and 4 show a similar trend for both shifts. Standards 6 and 7 increased considerably for the a.m. shift but they continued at a low level for the p.m. shift.

These data indicate that staff in the experimental condition (a.m. shift) were better able to write notes according to the DATA-ACTION-RESPONSE format, were signing their names correctly, and were indicating their interventions with the patients as well as the patients' responses to these interventions. Staff were also describing the patients' behaviors in observable terms, relating them to their treatment plans, and abstaining from the use of derogatory terms. The p.m. shift showed extreme deficits in the use of the DATA-ACTION-RESPONSE format, the use of observable terms, and the use of correct signatures.

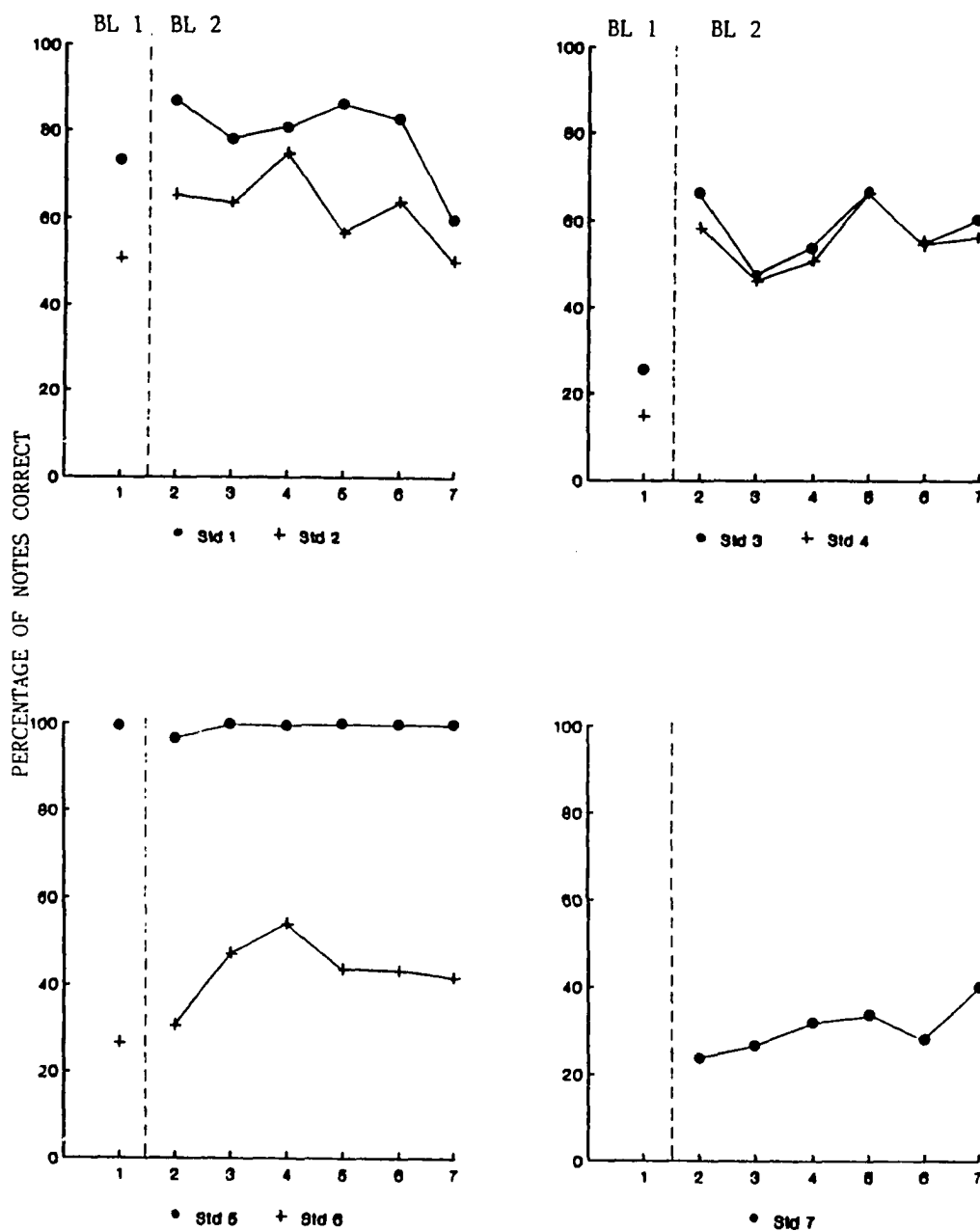
Figures 5 and 6 show staff performance for each standard in unit 2. For the a.m. shift, standards 5, 6, and 4 show the highest scores, but the trends indicate, as did all standards, that gains are being maintained over time. The p.m. shift graphs show a similar trend with a slightly higher performance on standard 2.

Figures 7 and 8 show staff performance for unit 3. Both shifts show similar trends. Again, standard 5 shows the highest scores. Standards 3 and 4 and 1 and 2 show similar trends; however, the former two show an upward trend while the



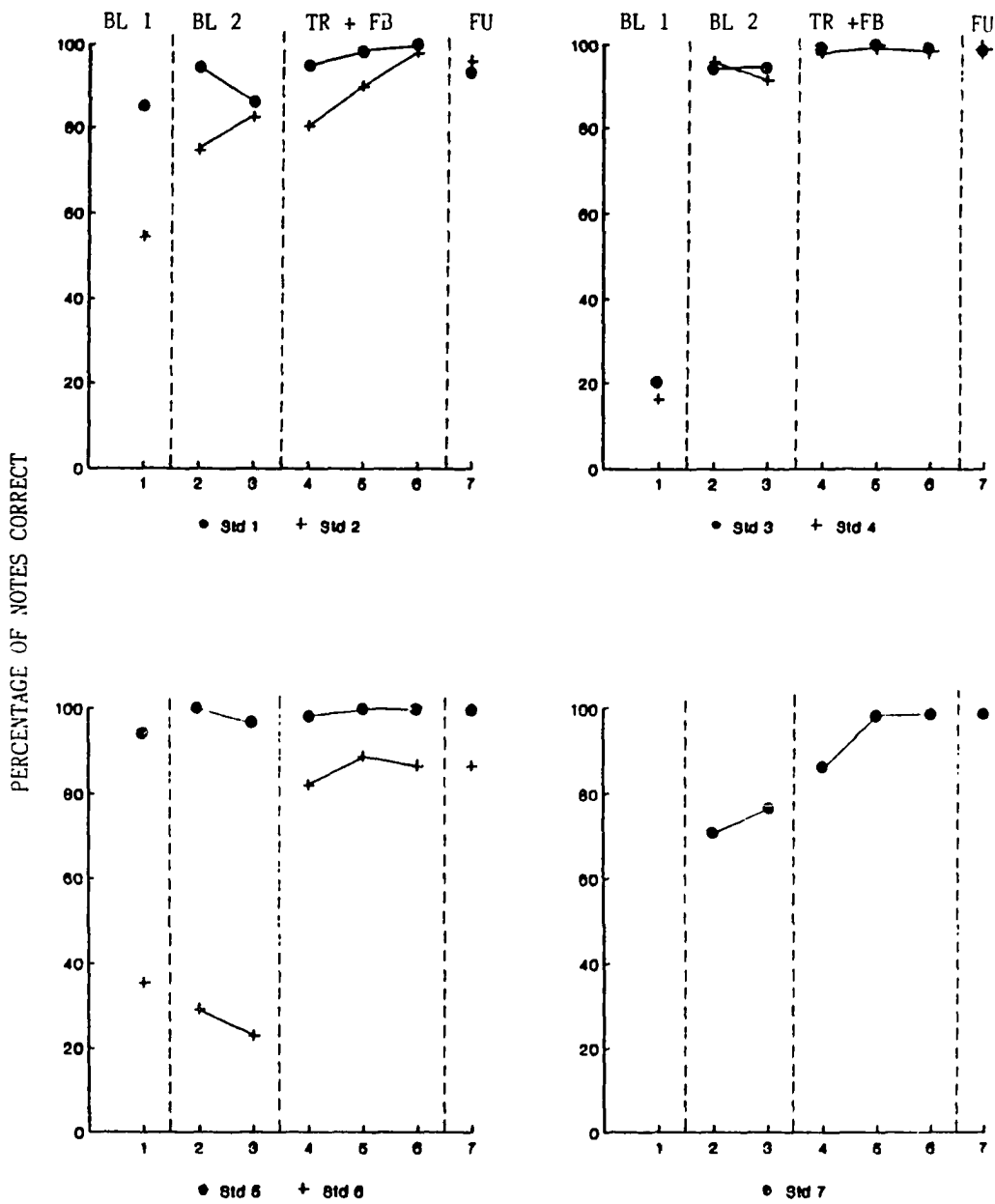
Note. BL = Baseline, TR = Training, FB = Feedback, FU = Follow-up

Figure 3. Percentage of Notes Correct by Standard for Unit 1 (a.m. Shift).



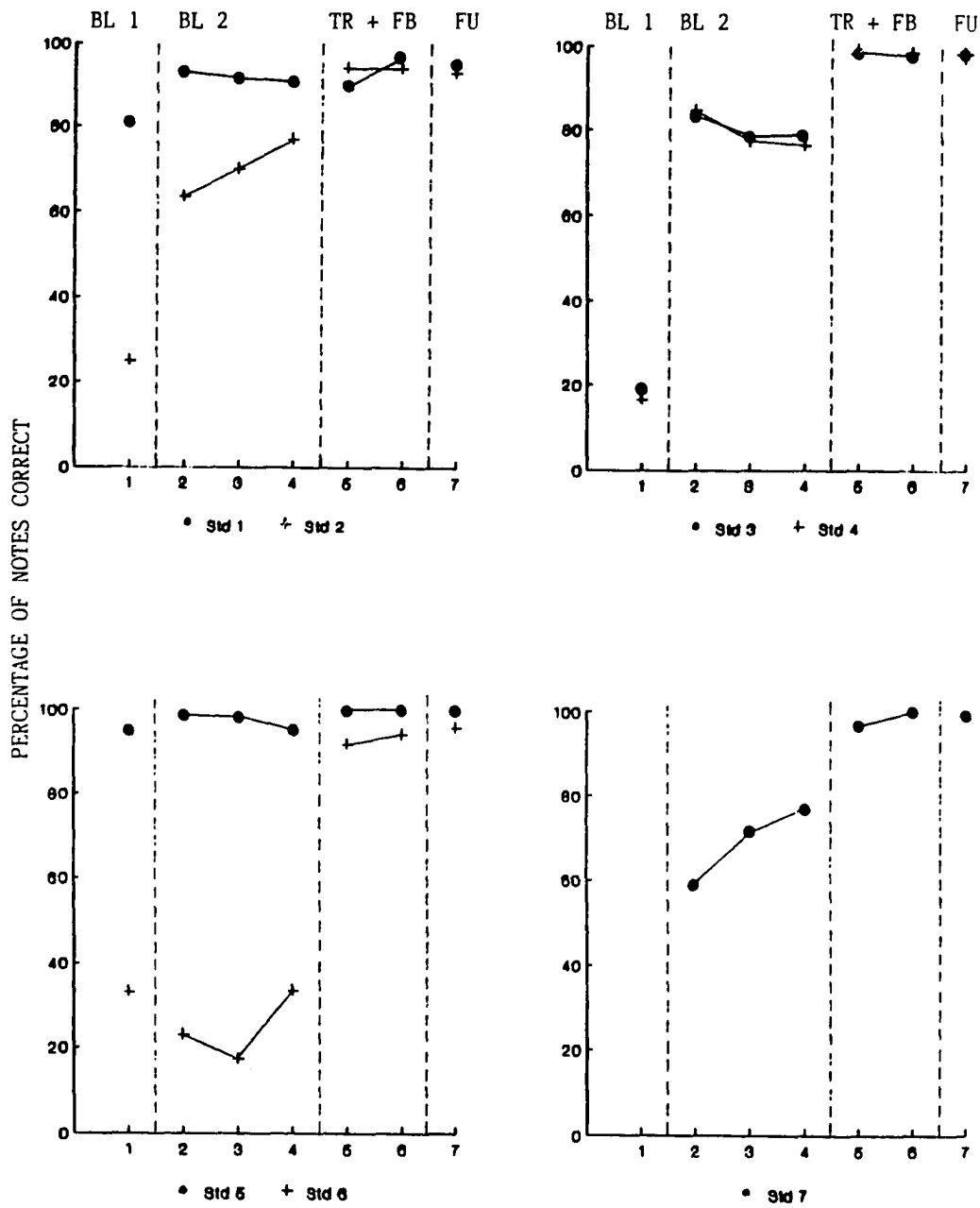
Note. BL = Baseline

Figure 4. Percentage of Notes Correct by Standard for Unit 1 (p.m. Shift).



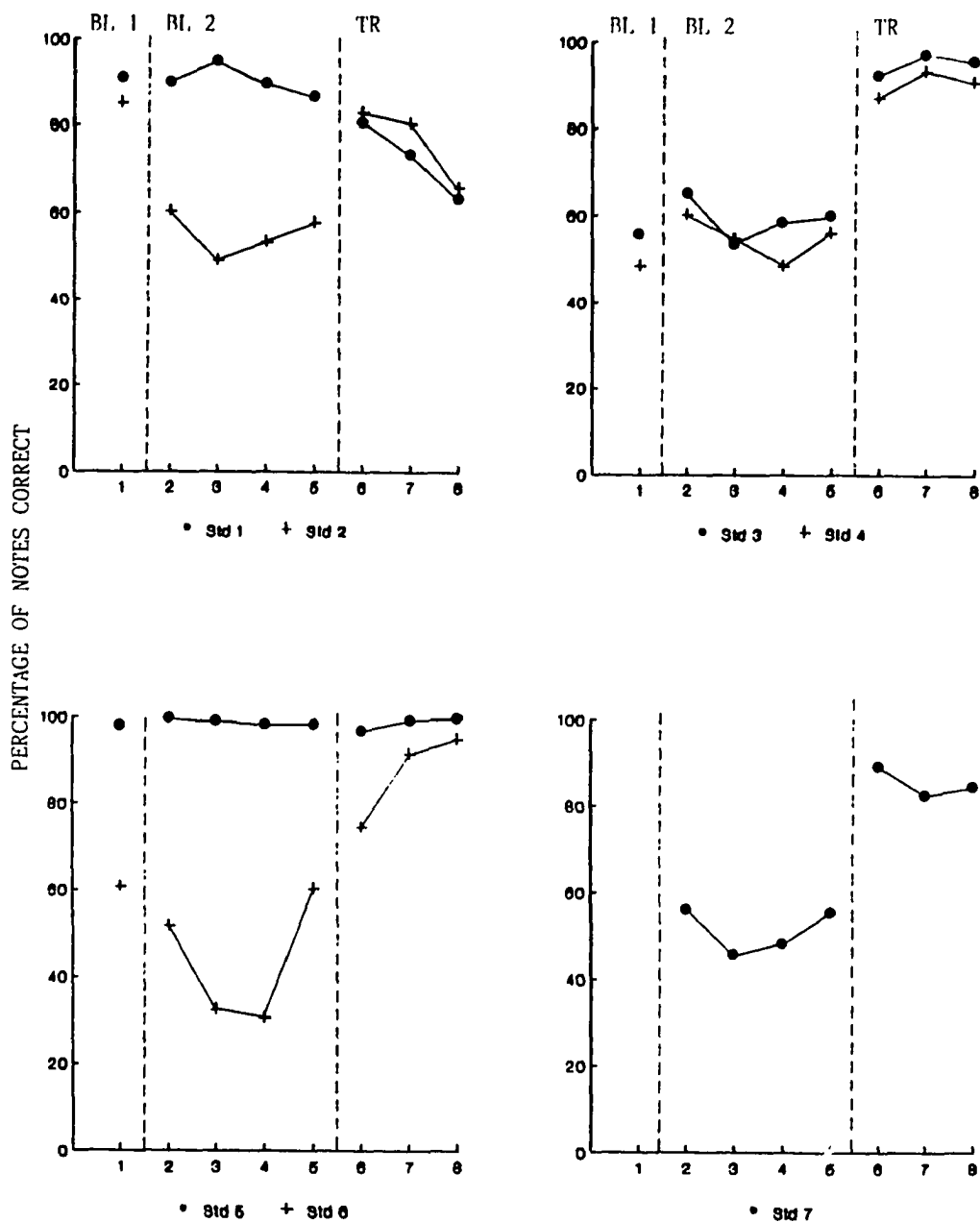
Note. BL = Baseline, TR = Training, FB = Feedback, FU = Follow-up

Figure 5. Percentage of Notes Correct by Standard for Unit 2 (a.m. Shift).



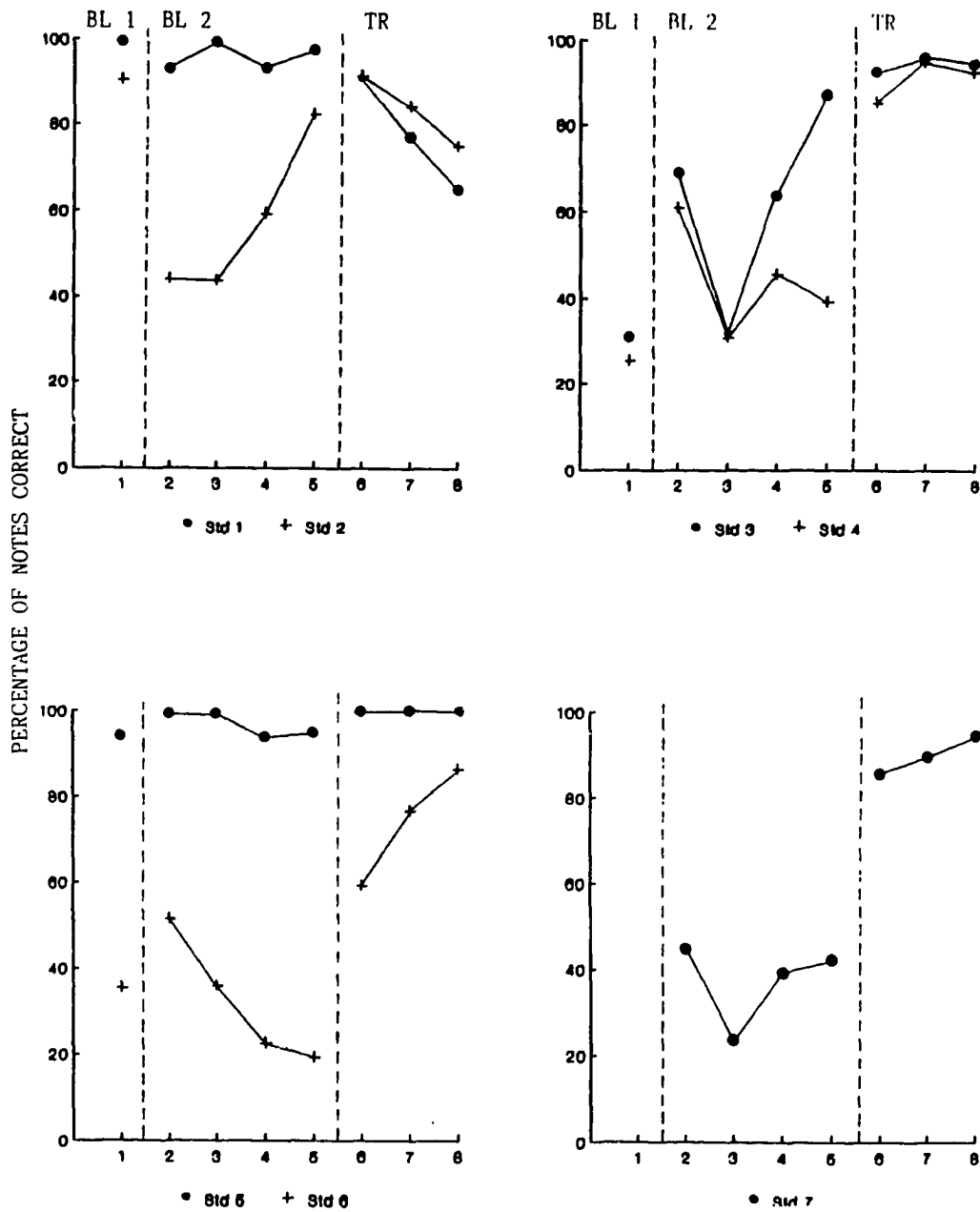
Note. BL = Baseline, TR = Training, FB = Feedback, FU = Follow-up

Figure 6. Percentage of Notes Correct by Standard for Unit 2 (p.m. Shift).



Note. BL = Baseline, TR = Training

Figure 7. Percentage of Notes Correct by Standard for Unit 3 (a.m. Shift).



Note. BL = Baseline, TR = Training

Figure 8. Percentage of Notes Correct by Standard for Unit 3 (p.m. Shift).

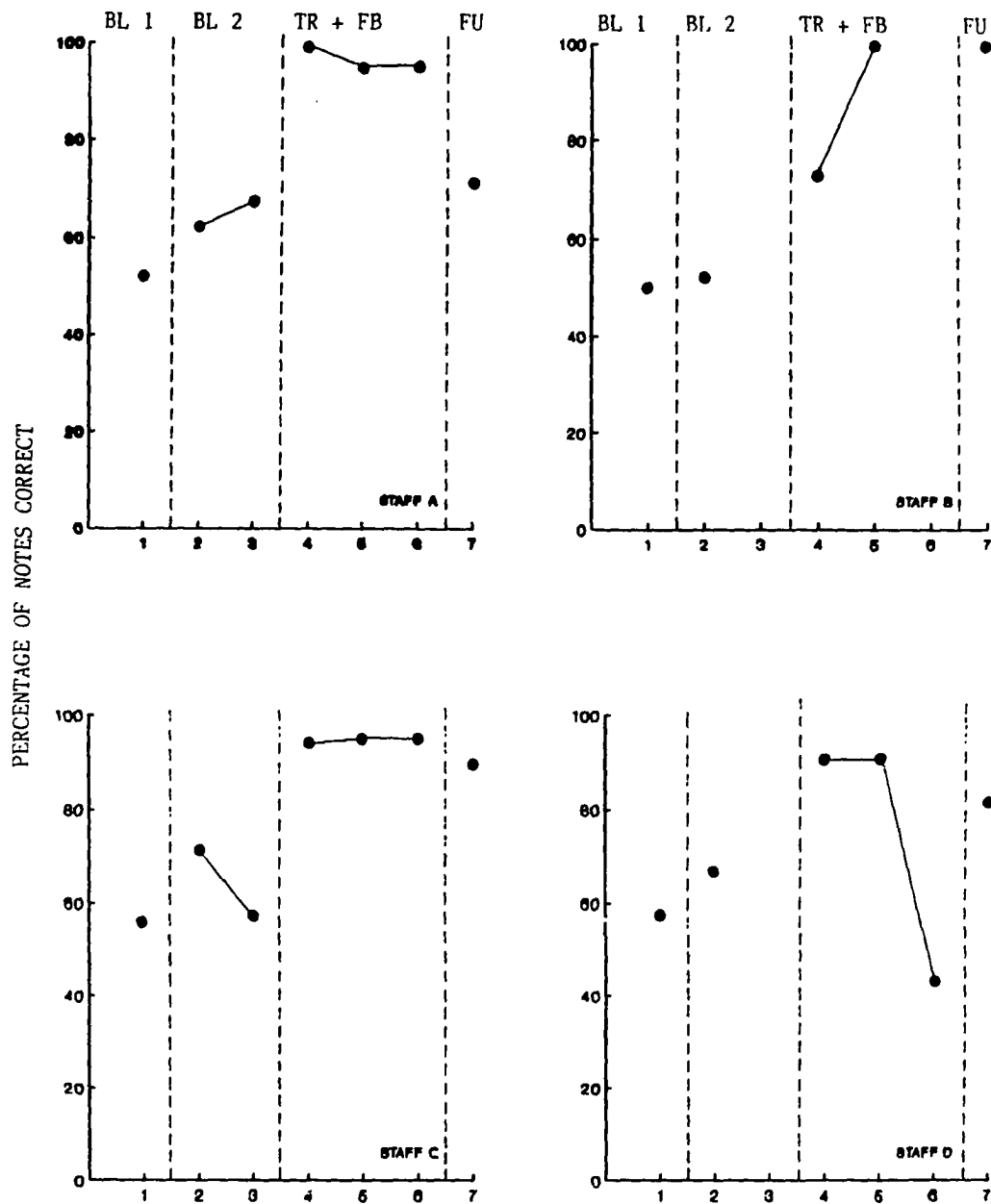
later two show a downward trend. Standards 6 and 7 show the least improvement of all. Staff in this unit showed the lowest levels at baseline and therefore their overall improvement was the most significant.

Performance by Staff

Figure 9 shows the overall performance of each individual staff for unit 1 (only a.m. shift scores were considered individually since the p.m. shift ones were averaged as a group). There was a substantial individual improvement with regard to the efficacy of the independent variables. Staff A, C, and I showed an immediate improvement while performance of staff G showed the lowest scores.

Figure 10 shows staff's performance in unit 2 (a.m. shift). Again, all staff show improvement with the only difference that their scores were higher during baseline. For the p.m. shift (Figure 11), staff P showed the highest improvement in comparison to baseline.

Figure 12 shows performance on unit 3 (training-only condition). For the a.m. shift, staff A, F, and D showed a sharp increase after the independent variable was presented. Staff J showed a very erratic performance mainly due to writing notes sporadically or not at all. For the p.m. shift (Figure 13), data do not look stable, especially for staff C and U who sometimes would write only one note in a month or not at all. Staff L and T started to work on this unit just before training was provided.



Note. BL = Baseline, TR = Training, FB = Feedback, FU = Follow-up

Figure 9. Percentage of Notes Correct by Individual Staff Performance for Unit 1 (a.m. Shift).

Figure 9--Continued

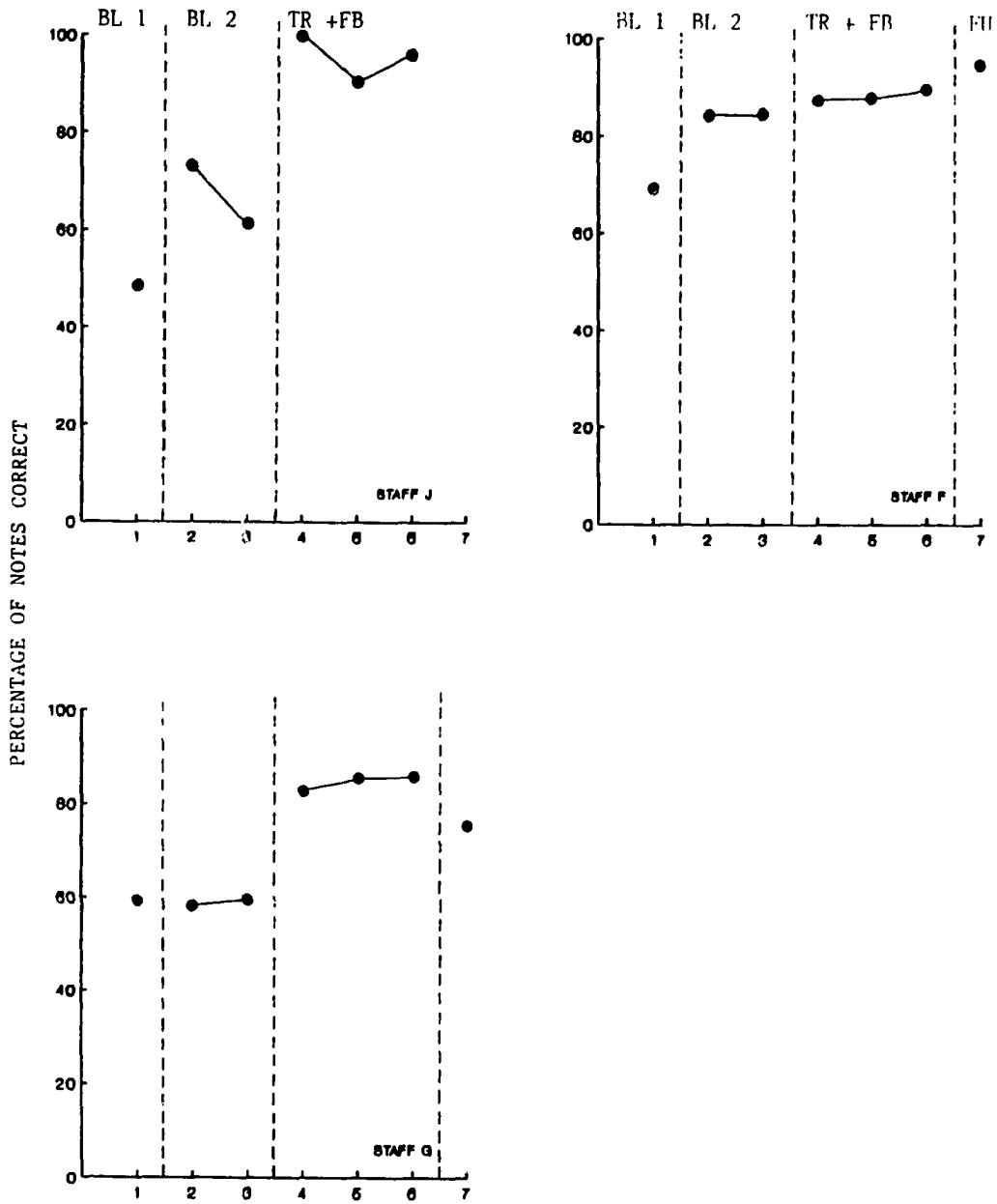
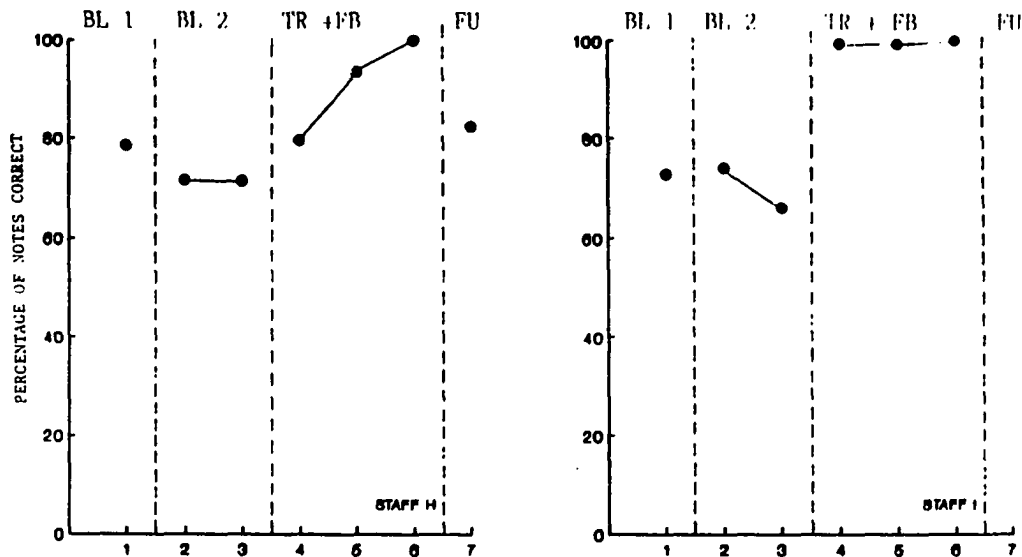
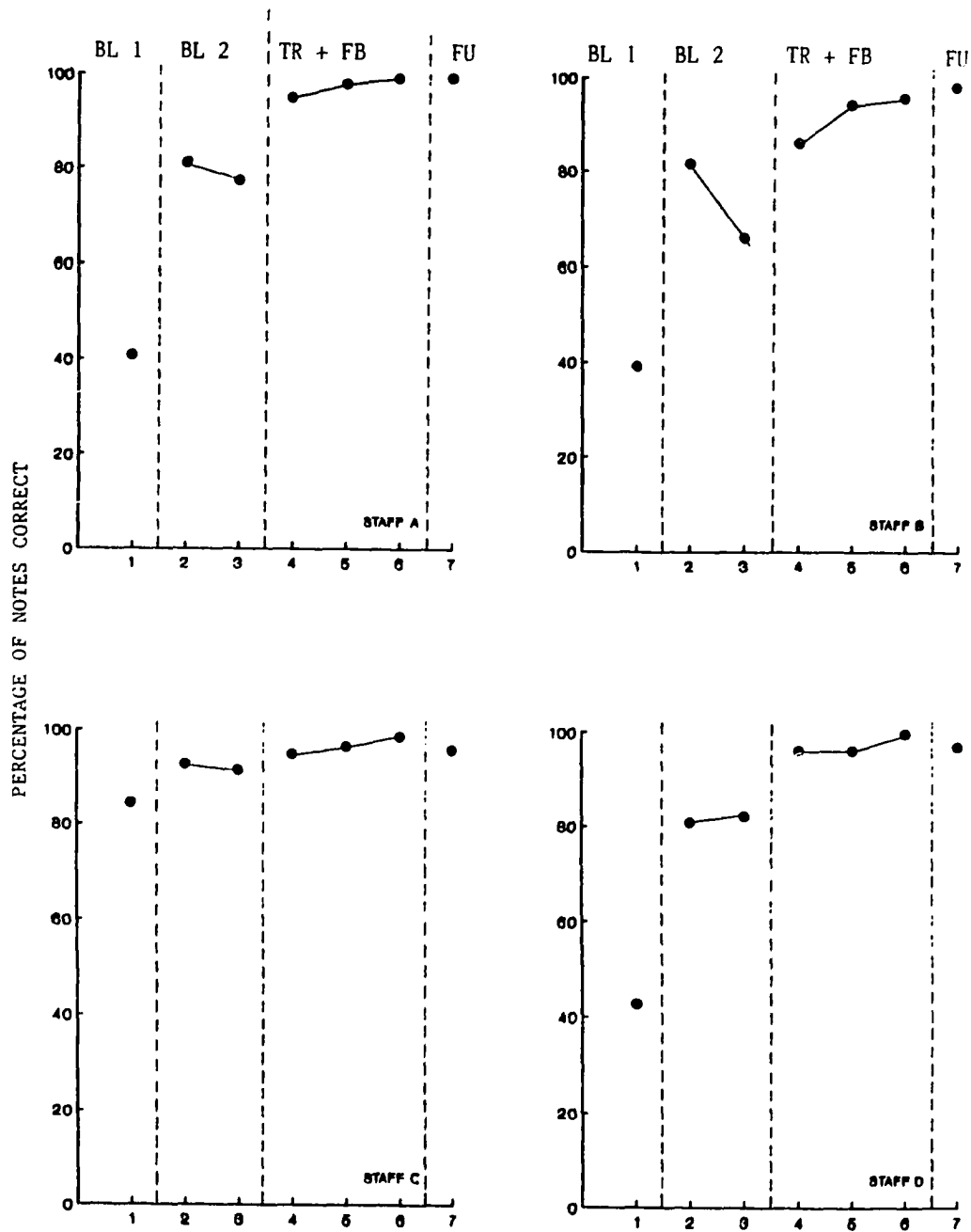


Figure 9--Continued



Social Validation

A social validation questionnaire was administered one week after training for unit 3 and after one week before follow-up for units 1 and 2. Eighty percent of the staff were surveyed (see Appendix D). One hundred percent indicated that the workbook and the examples given were helpful in clarifying situations discussed during training. Ninety-six percent said that the training sessions were helpful; 68.75% said that they had a better understanding of what is expected from them when writing progress notes; and 90.62% thought that they will meet standards better. Eighty-three percent said that weekly feedback in the form of graphs and verbal feedback was useful in clarifying certain questions and served as a motivational variable. Some of them stated that it was nice to have somebody look at their performance and praise them when they were doing well.



Note. BL = Baseline, TR = Training, FB = Feedback, FU = Follow-up

Figure 10. Percentage of Notes Correct by Individual Staff Performance for Unit 2 (a.m. Shift).

Figure 10--Continued

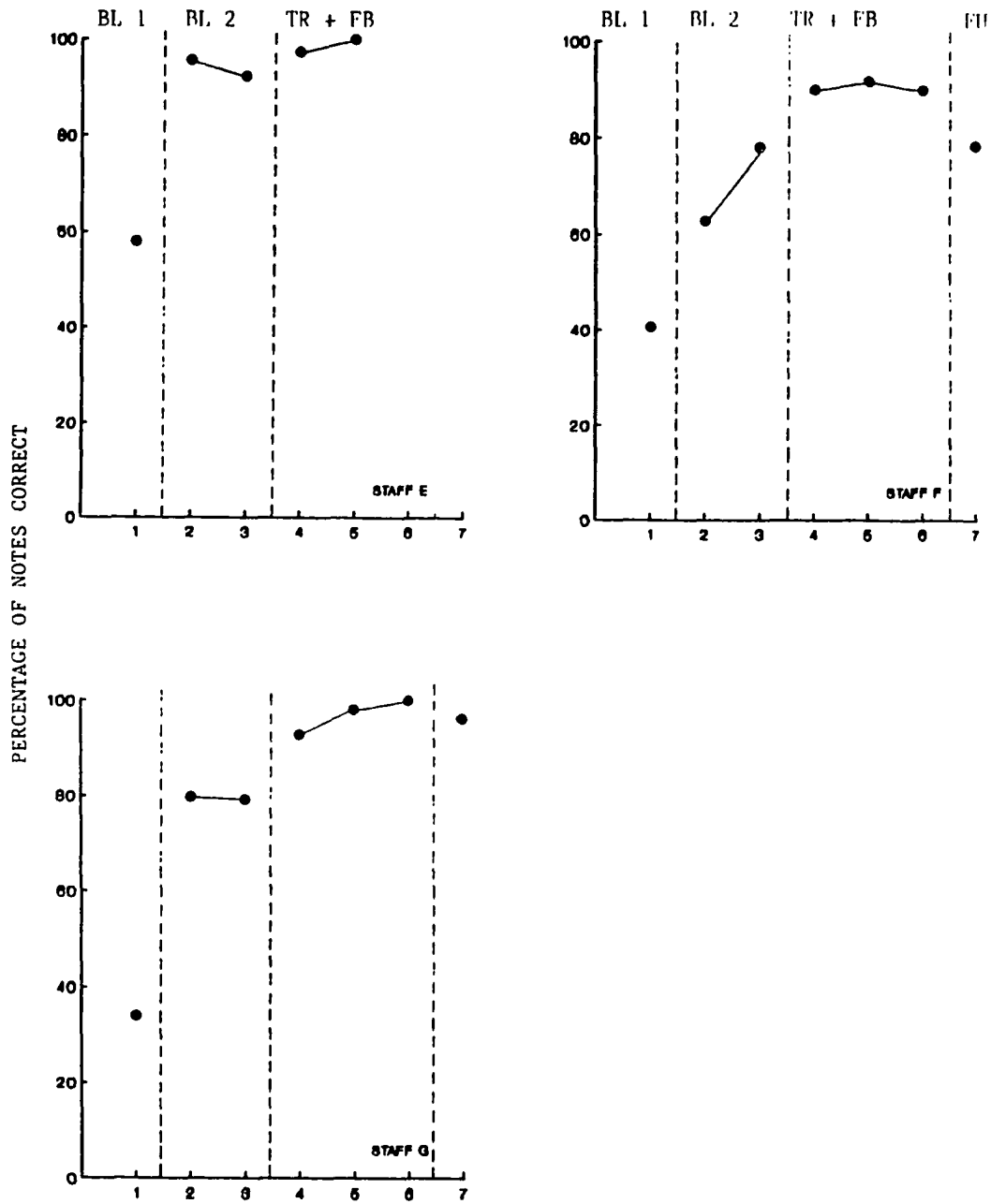
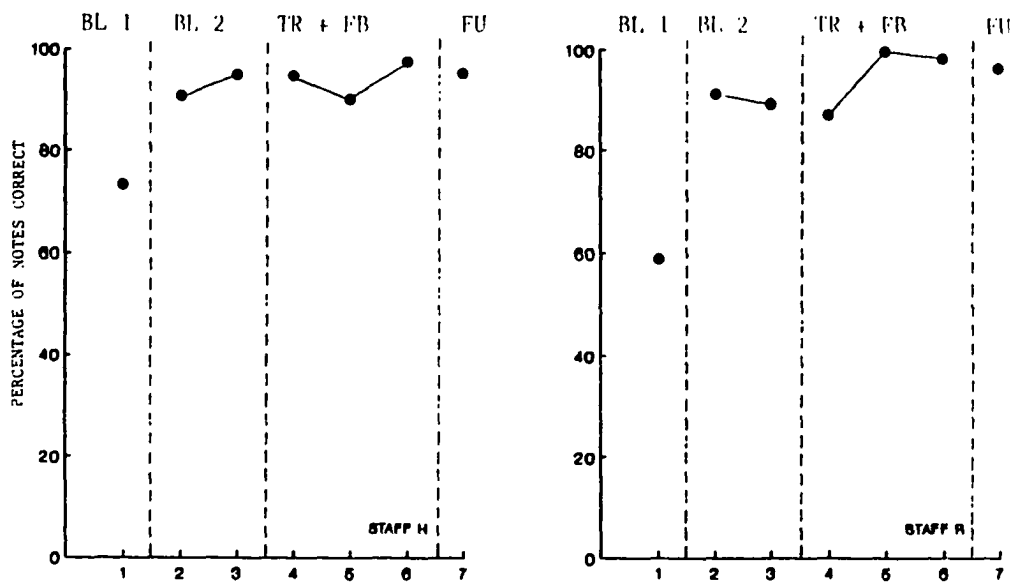
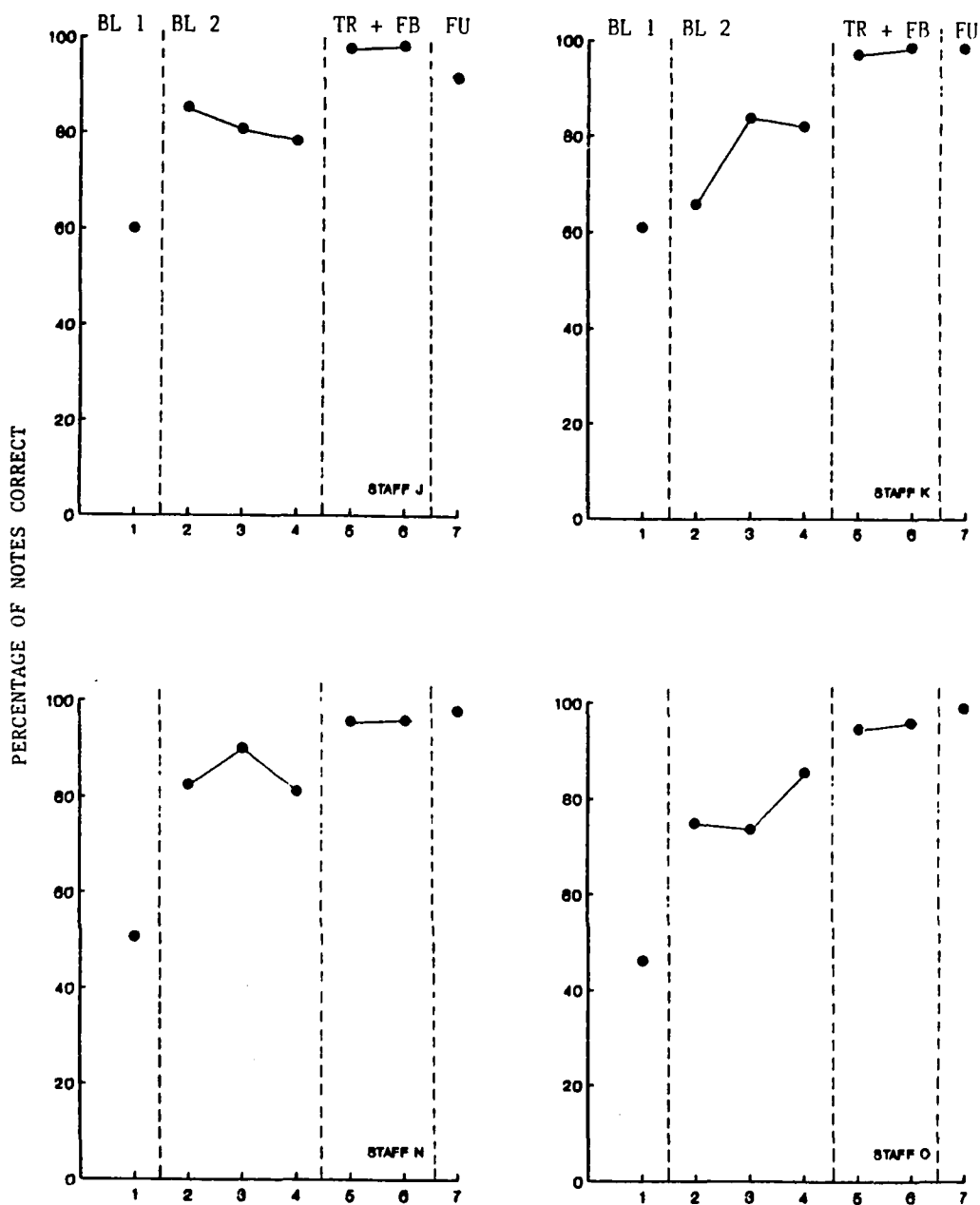


Figure 10--Continued



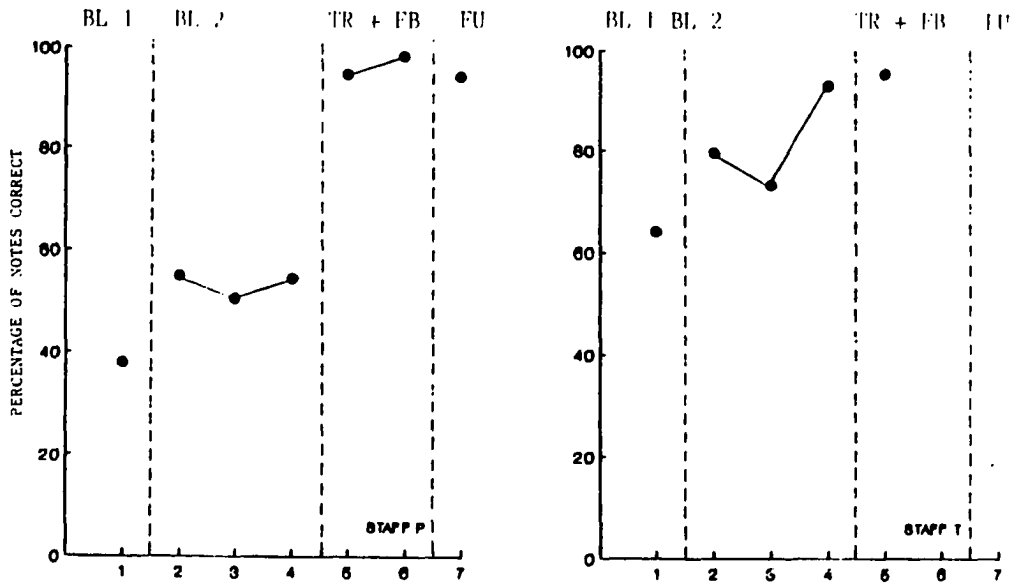
Sometimes, staff would make comments such as "We are doing great!" or "I bet we did better than the ... shift."

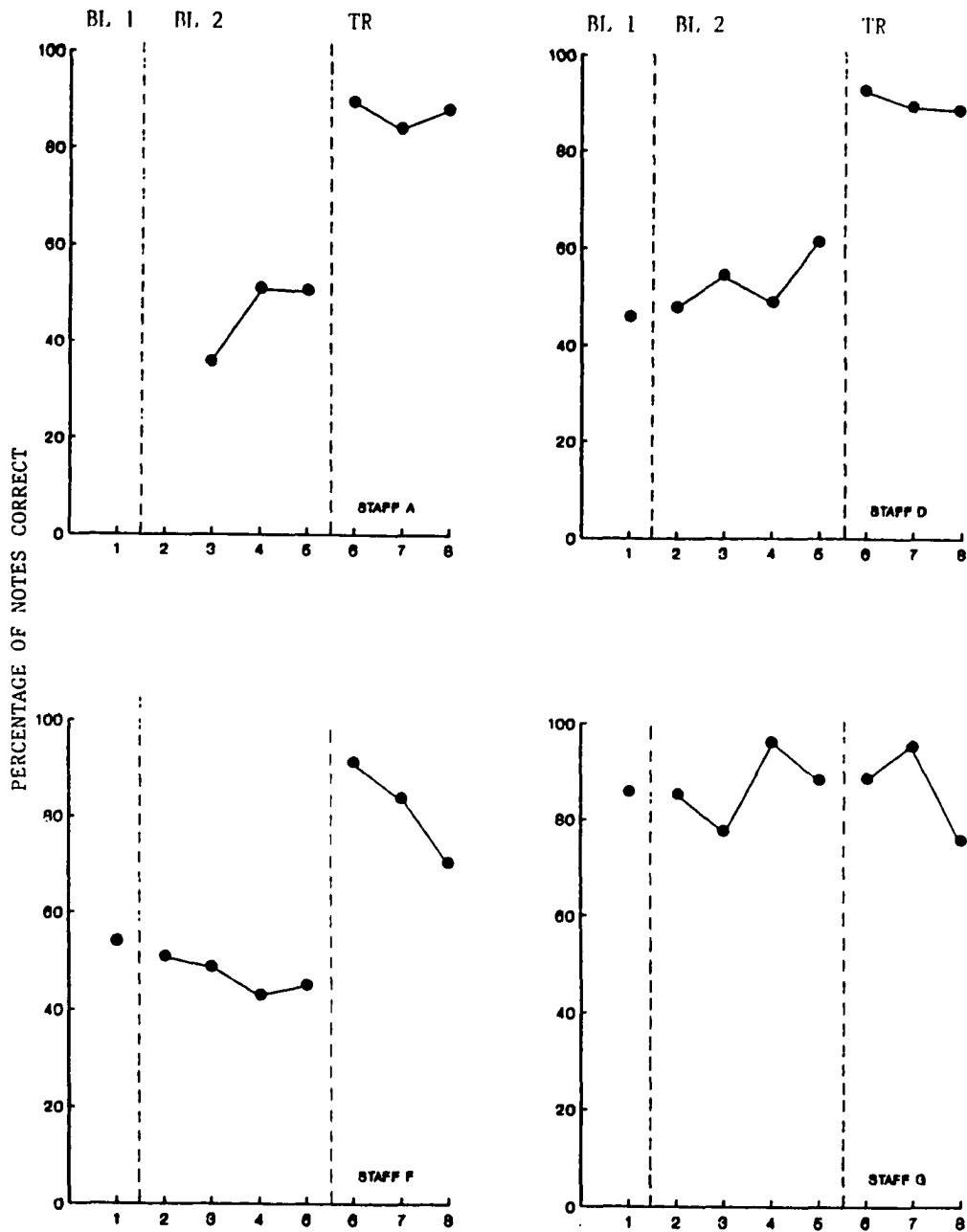


Note. BL = Baseline, TR = Training, FB = Feedback, FU = Follow-up

Figure 11. Percentage of Notes Correct by Individual Staff Performance for Unit 2 (p.m. Shift).

Figure 11--Continued

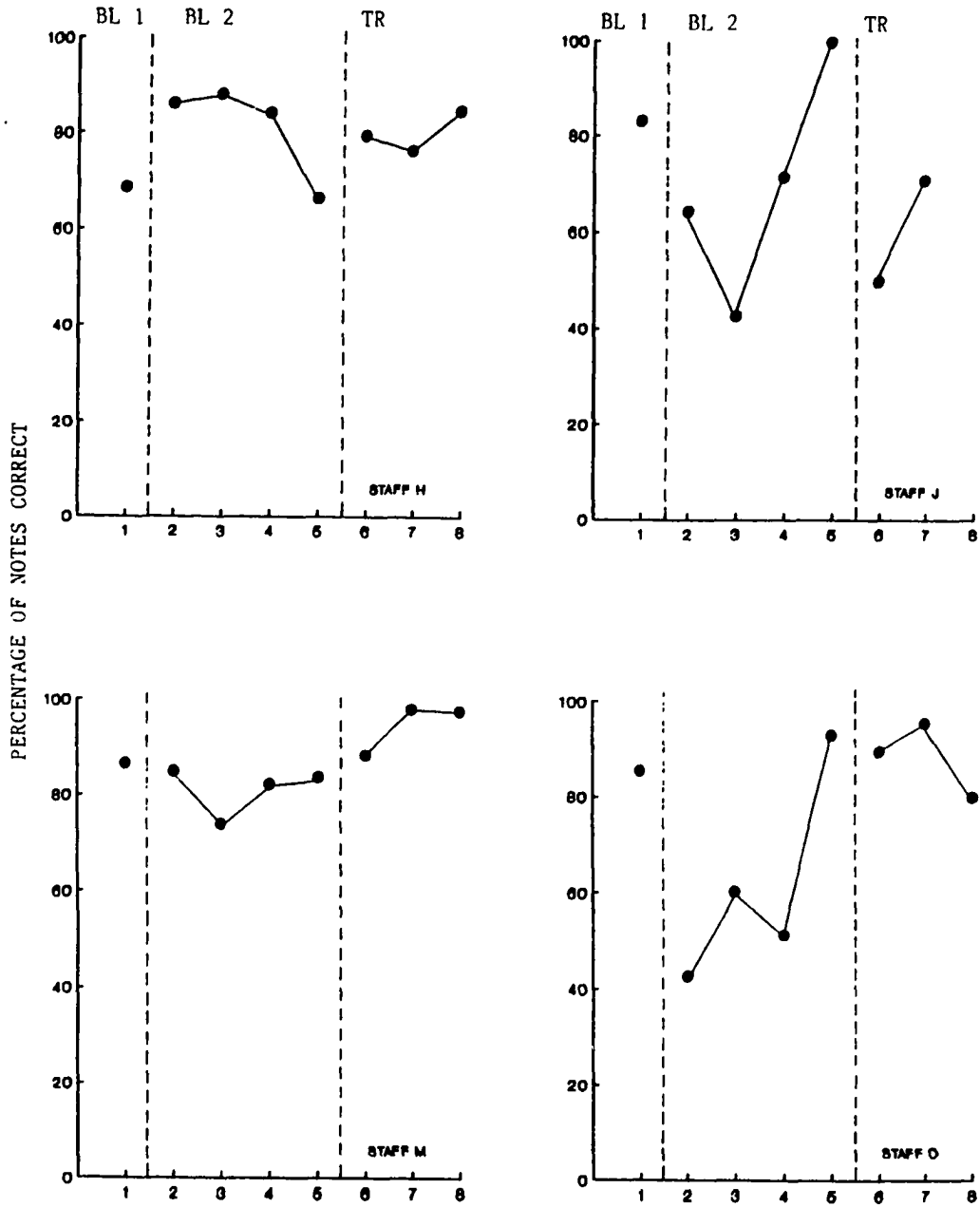


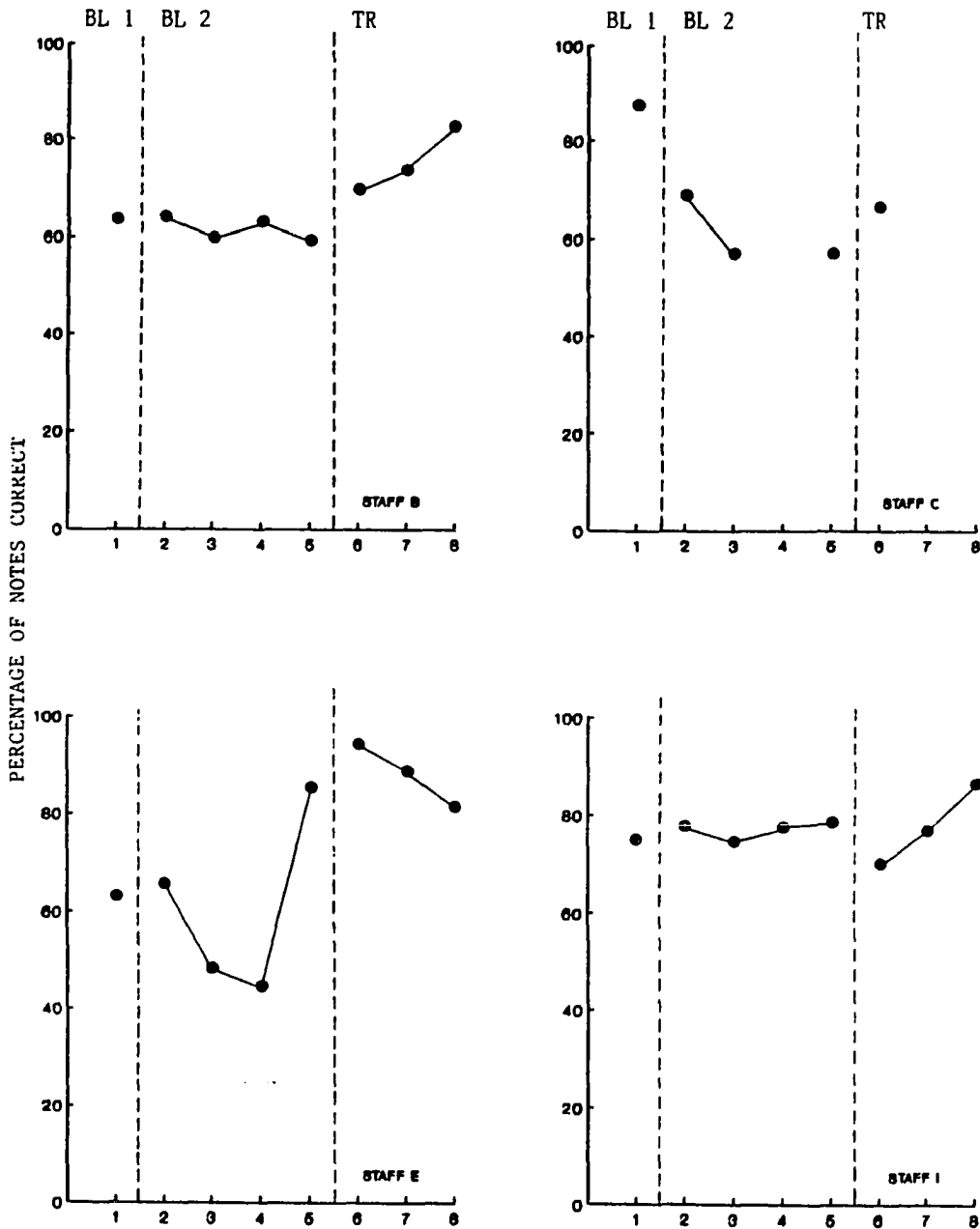


Note. BL = Baseline, TR = Training

Figure 12. Percentage of Notes Correct by Individual Staff Performance for Unit 3 (a.m. Shift).

Figure 12--Continued

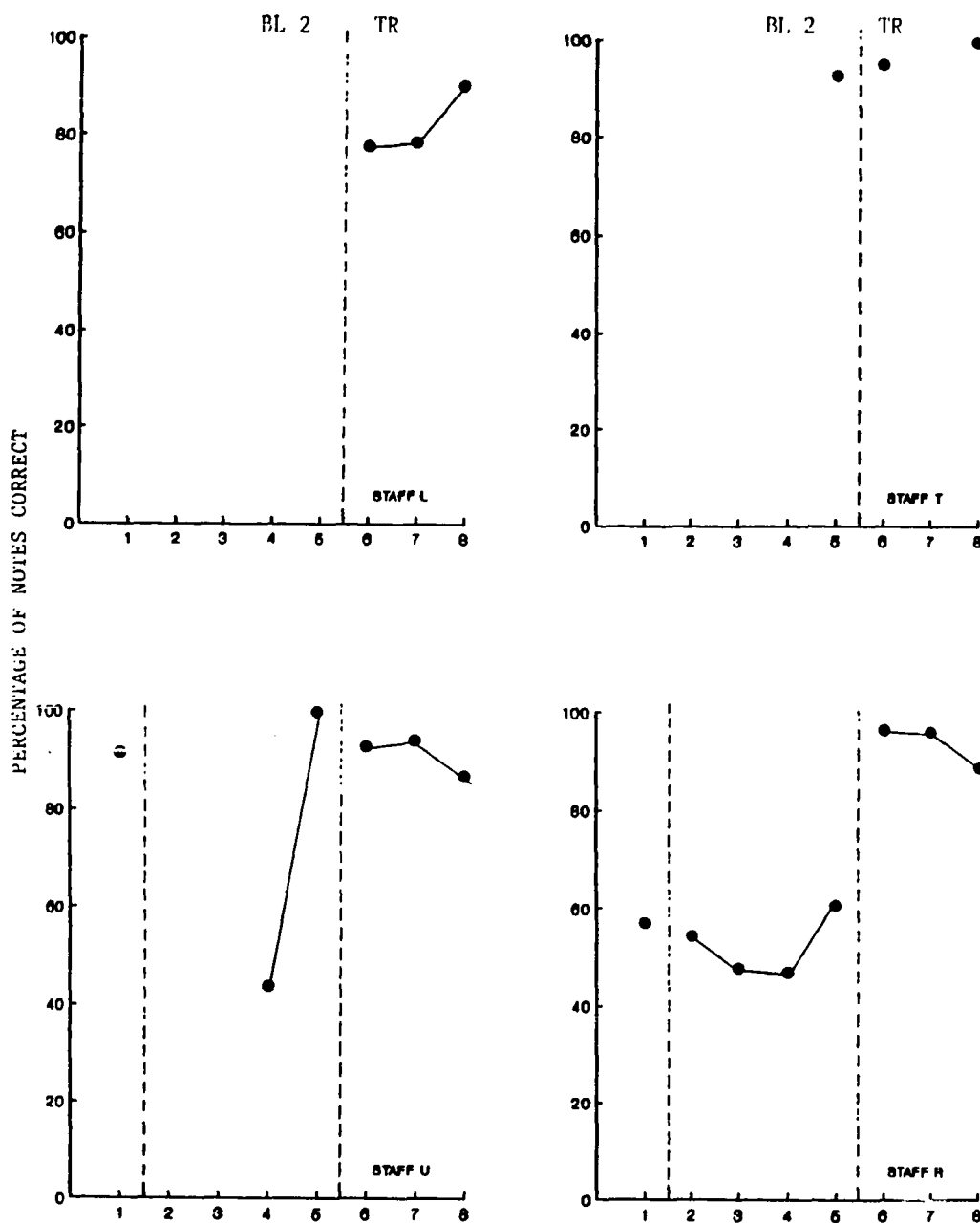




Note. BL = Baseline, TR = Training

Figure 13. Percentage of Notes Correct by Individual Staff Performance for Unit 3 (p.m. Shift).

Figure 13--Continued

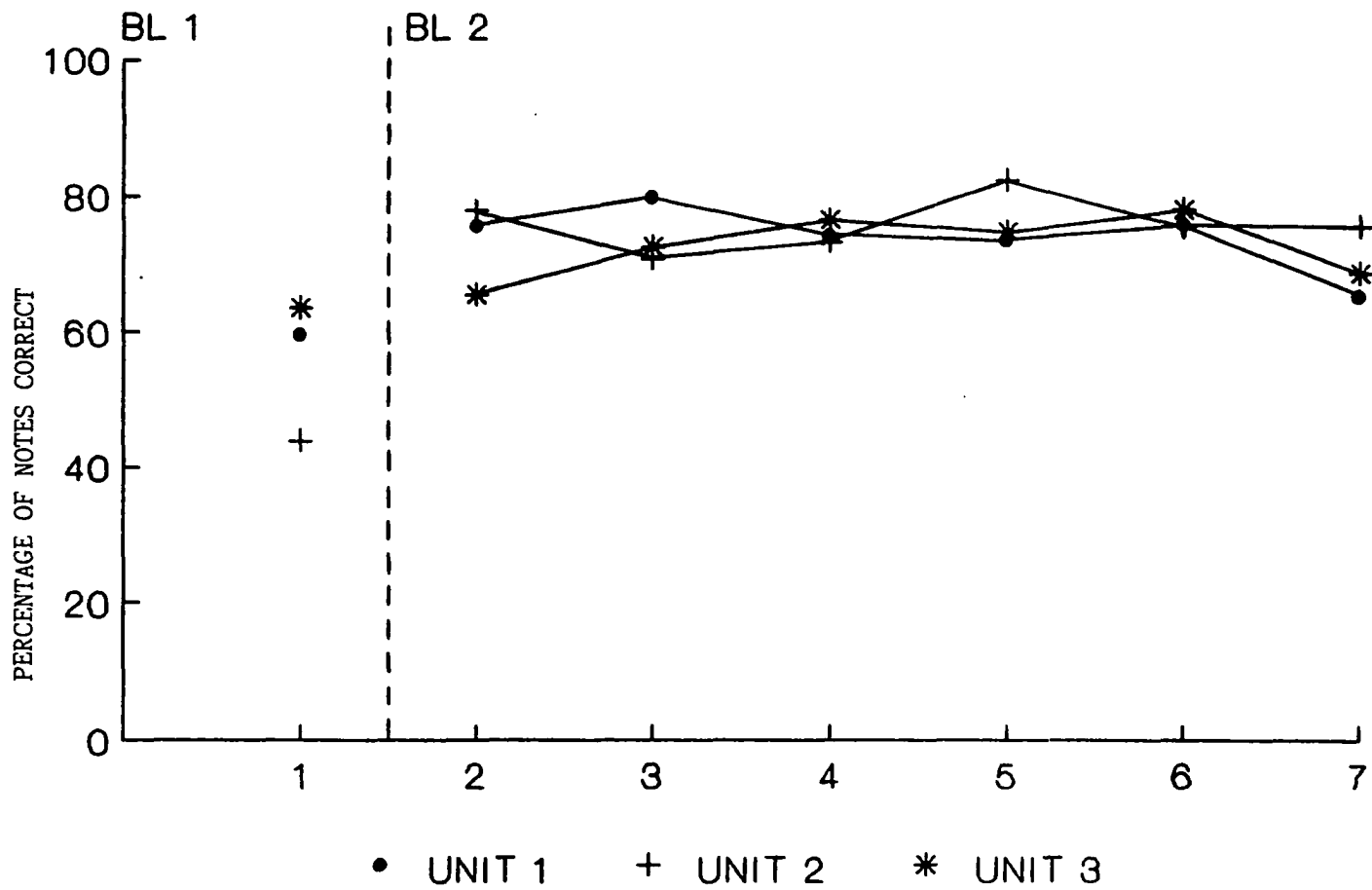


CHAPTER IV

DISCUSSION

The results of the present study highlight the importance of consequent control in maintaining performance. When staff members received training in the form of verbal explanations and written materials, performance improved dramatically. It was not until the feedback was provided that performance maintained a more consistent level. The data from the training-only groups revealed the greatest improvement, but it is not clear whether this effect would have been maintained over time. The trend indicated that scores were moving downwards, especially with regard to standards 1, 2, 3, and 4. Figure 14 shows the performance of a second control group, the supply staff. As indicated, they maintained a mean level of 73% which is rather low in comparison to the other groups. The results of the present study suggest that although proper training is essential, more attention should be devoted to the provision of consequences for desired performance, and that feedback is an accepted and cost-effective motivational strategy. These results differ from those of Jones et al. (1986) in that the training-only group did show a significant improvement.

A common feature of many behavioral programs is the clarification of performance standards (Komaki et al., 1980). In the present study, for example, progress notes standards were defined before baseline, staff were told and given



Note. BL= Baseline

Figure 14. Percentage of Notes Correct by Supply Staff in all Three Units.

written examples of accepted standards during the training phase, and the criteria of acceptance were set during the feedback phase.

Since the source of feedback was the same individual, the credibility of the feedback source can be assumed to be high. The feedback was specific and delivered in a fashion that was simple enough to be understood (see Appendix F). Data obtained from the social validation questionnaire indicated that staff found weekly feedback useful in clarifying the new charting system.

Providing positive reinforcement and information about satisfactory performance have been neglected at the experimental setting. This may explain why the staff found it rewarding to receive positive feedback on how well they were doing. Negative comments were avoided and this may have helped staff morale which has not been very high at the hospital for several years.

In order to evaluate whether training produced the desired effects, the four levels of evaluation described by Brethower and Rummel (1977) were used:

1. Were the trainees happy with the training?
2. Did the training course teach the concepts?
3. Were the concepts used on the job?
4. Did application of the concepts positively affect the organization?

As stated previously, staff stated that they found training useful, and they especially liked the examples given in the workbook. A few of them showed some initial resistance to change, but, once they learned that the purpose was to facilitate documentation, they found it helpful. The concepts taught were consistent with the standards set by the Nursing Department and outside

accreditation agencies. Results showed the usage of the new learning on the job. It is not certain to what extent the improvement on progress notes affected the organization; however, it is possible that this improvement would have some impact on whether accreditation agencies consider the medical record to be legally sound.

It should be pointed out that no data were collected on the impact of more informative progress notes and the decision-making process of whether a patient should be granted more privileges or be considered for discharge. This was not within the scope of this study but merits further investigation. In addition, no data were collected on changes between patient-staff levels of contact. The only data which bear on this issue are the subjective reports of staff during the social validation questionnaire. Some of them reported that their interactions with the patients had increased. It would be worth-while to determine the role of these interactions.

Plausible alternative hypotheses, such as history and maturation, were ruled out because all phases were introduced at different points in time and improvements occurred after, and not prior to, the introduction of these phases.

Although it is widely accepted that consequences should be provided frequently and that less reinforcement is necessary once the behaviors have been established, this study was not designed to determine how often feedback should be provided. Based on the consistency of staff performance from week to week, it is recommended that feedback be presented at least monthly, be positive, and that the staff be given an opportunity to discuss its content. It is also

recommended that use of the training manual containing the progress notes standards be required of all the nursing staff at the hospital. Furthermore, it would be valuable to assess the effects of such variables as providing advice regarding possible staff interventions, presenting individual feedback, and presenting feedback on some standards and not on others.

In addition to raising a variety of questions for future research, the present study demonstrates the efficacy of training and feedback in improving adherence to progress notes standards.

APPENDICES

Appendix A
Goal Statement and System Description Aid

GOAL STATEMENT

My general goal as a researcher was to develop a feedback system and provide training to nursing staff on how to write progress notes for each individual patient on their unit.

The ideal was to use this feedback system and training with all staff at the hospital so progress notes on patient's records became more informative and useful in the evaluation of overall progress.

Some of my missions were:

- 1) To identify standards for progress notes that met KRPH, JCAHO, and HCFA requirements.
- 2) To develop a training manual for staff that described the standards that progress notes had to meet to be considered acceptable.
- 3) To provide a 2-day training session to staff on how to write progress notes.
- 4) To develop a feedback system which included public posting of group performance on each progress note standard identified.
- 5) To meet with nursing supervisors to discuss about group progress.
- 6) To meet with nursing staff weekly to provide feedback and explanation of performance graphs.
- 7) To develop good interpersonal relations with staff.

GOAL STATEMENT

A) PHILOSOPHICAL LEVEL:

- Improve quality of documentation that would help to make accurate decisions about patient's future (further hospitalization or discharge).

B) CULTURAL LEVEL:

- Provide patients with trained staff who could write better notes about their progress that would have some impact in the decision of whether they need further hospitalization.
- Greater level of staff-patient interaction.

C) POLICY LEVEL:

- Staff with improved note-writing skills.

D) STRATEGIC LEVEL:

- Selection of staff for training on how to write progress notes according to standards.
- Training staff on how to write more informative progress notes that can be used in the decision-making process on whether a patient needs further hospitalization.

E) TACTICAL LEVEL:

1) Two one-hour training sessions.

- 1.1) Discussion and demonstration on how to write progress notes through the use of examples and non-examples.

2) Implementation of a feedback system.

- 2.1) Public postings (graphs) on the group performance of weekly progress

notes for each unit.

F) LOGISTIC LEVEL:

- Materials and tools required for the tactical level.

STRUCTURED DESIGN WORKSHEET

STEP ONE: OVERVIEW OF THE PROPOSED INSTRUCTIONAL UNIT

TOPIC: Progress notes training. Action: to teach nursing staff how to write progress notes that meet KRPH, JCAHO and HCFA standards. Area: Skills training.

CONTEXT:

Setting: Kalamazoo Regional Psychiatric Hospital.

Permanent products: 1) Increased number of progress notes containing: a) relation between note and patient's treatment plan; b) patient's behaviors described in measurable terms; c) description of staff actions when dealing with the patient; d) description of patient's response to staff actions; e) staff signatures; f) no derogatory terms; and g) proper D-A-R format.

Samples of past progress notes will be used as examples and non-examples using patients' most common behaviors during hospitalization.

POTENTIAL BENEFITS:

Staff will learn how to write notes that meet KRPH/HCFA standards that will provide factual information about the patient's progress. If instruction (training) is successful, hospital administrators might recommend other disciplines to get the same training.

Staff will get positive feedback for their good performance, and will get more compliments from their supervisors or peers.

If notes contain more thorough information about how the patient is doing in relation with his/her reasons for admission, then decisions taken on whether he/she needs further hospitalization would be more accurate.

Patients might spend less time hospitalized if progress has been documented efficiently.

Staff-patient interactions might improve when staff is being required to describe their interventions with the patient.

With the use of group feedback, costs of implementation would be minimal.

POTENTIAL FOR MAINTENANCE:

If nursing staff learn to write progress notes that meet required standards and provide better information of patient's progress, the Nursing department will get social recognition from administration and other departments. Also, the Justice department and JCAHO will provide positive feedback for having progress notes meetings the standards required.

If training is successful, other departments will be more likely to use this training and feedback package and get financial support and social recognition.

STEP TWO: DEMONSTRATION OF MASTERY (INPUTS, OUTPUTS AND CRITERIA)

OUTPUTS:

Nursing staff with better skills on how to write progress notes according to

standards. Permanent products: Written progress notes related to patient's treatment plan, patient's behaviors described in observable terms, written description of actions taken by staff and patient's response to these actions, absence of derogatory terms, and, staff signatures on every note.

Number of correct responses to practice exercises.

INPUTS:

Staff will receive social recognition and positive feedback for good performance. They will also get a training manual including examples and non-examples of progress notes. They will engage in discussions and guided practice exercises. Examples used will reflect real every day situations.

CRITERIA FOR EVALUATION:

Progress notes standards will be clearly specified so that staff will be able to determine whether they are meeting these.

Weekly feedback graphs will contain clear and specific information on group performance.

Baseline data will be accessible to staff so that they can make comparisons. Results will be more credible this way too.

Criteria of merit will be a percentage of not lower than 92% of correct progress notes.

Appendix B
Focus Charting Training Materials (KRPH)

FOCUS CHARTING PROCESS

The Focus Charting model referenced herein has been developed by Susan Lampe, 1985. Further information can be obtained from Lampe, S., "Focus Charting: Streamlining Documentation", *Nursing Management*, 16(7), 43-46.

Developed; January, 1990

Criteria needed for a good charting system:

- A. The patient chart will be legally sound.**
- B. The patient chart will reflect the nursing process (assessment, planning, implementation, evaluation).**
- C. The patient chart will provide a current, complete, concise description of the patient's status with the least possible duplication of information.**
- D. The patient chart will record all nursing observations and treatments, and the patient response to the medical and nursing care given.**
- E. The patient chart will provide useful communication among disciplines.**
- F. The documentation system will be so integrated that the Care Plan and patient chart complement each other.**
- G. The documentation system will provide information in a format which can be retrieved for audit and/or research.**

DEFINITIONS NEEDED FOR FOCUS CHARTING

What is a "focus"?

A "focus" is a patient care related issue which consists of (1) a current patient concern or behavior, (2) a significant change in the patient's status or behavior, (3) a significant event in the patient's therapy. A focus is NOT A MEDICAL DIAGNOSIS. It is a statement of what is happening to the patient, sometimes as a result of a medical diagnosis. Foci delineate the occasions for and activities of the nursing care the patient is receiving. Anyone can identify a focus in the Patient Care Notes. Only a registered nurse can identify the foci described in the Nursing Care Plan.

What is an expected patient outcome?

The expected outcome is what the nurse who has developed the Nursing Care Plan anticipates the patient will achieve after the care described in the plan is administered by the nursing staff. The expected outcome must be written in measurable terms so that an objective determination of accomplishment can be made. There is no requirement for time of achievement in the Nursing Care Plan. Once the outcome has been measured and shown to be achieved, the registered nurse is responsible for signing the date and her/his signature discontinuation of the focus and need for intervention.

What is a nursing intervention?

The plan or action to be taken by the nursing staff is explained in the Nursing Care Plan as an intervention. It describes general methods which all staff will need to become familiar with and follow as well as specific nursing care activities which only licensed personnel may administer in the care of the patient. It is the method by which the registered nurse plans to accomplish the expected outcome.

What is meant by Data, Action, and Response?

The patient care notes are organized according to these categories as described:

- Data:** Information which supports the stated focus or describes observations at the time of a significant event in therapy.
- Action:** Immediate or future nursing actions based on the evaluation of the patient's condition.
- Response:** Description of patient responses to any part of the care given.

Although staff are encouraged to use all three categories in every notation there may be instances when there is not a comment to make in one or another of them.

What is the Format?

A three column format organizes the information in the narrative section of the patient chart. It looks like this:

<u>Date/Hour</u>	<u>Focus</u>	<u>Patient Care Notes</u>	
Month/Day Hour of day	From NCP	Data:	Patient behaviors Patient status Nursing observations
	From staff observation	Action: Response:	Plans for nursing actions. Patient response to nursing and/or medical care.

The separation of the focus statement helps to retrieve data more easily and enhances the communication process. A scan of the focus column permits location of the desired information more quickly than the narrative style of nurse's notes traditionally used in the past.

Miscellaneous Standards:

- A. Focus Charting assumes that flow sheets, vital signs, graphs, etc. are being used to document monitoring activities and routine nursing tasks. Information recorded on a flow sheet need not be repeated in the Patient Care Notes unless that information will clarify or substantiate the record.
- B. A notation in the Patient Care Notes should be made whenever pertinent data or information related to the patient's status is identified. This narrative can relate to an already identified FOCUS (either from a previous note or the Nursing Care Plan) or to a newly identified FOCUS.
- C. More than one FOCUS can be identified under the same Date/Hour notation. The entire entry needs to be signed by the staff member making the notation at the completion of the documentation. The classification of the employee shall be recorded beside the signature.
- D. If more than one action is planned or taken they should both be recorded in a consecutive manner beneath the Data entry. If desired these can be numbered to increase legibility.
- E. The initials "D", "A", "R" may be used in place of the Data, Action, and Response headings.

KALAMAZOO REGIONAL PSYCHIATRIC HOSPITAL
 DEPT. OF NURSING SERVICES
 PATIENT CARE NOTES

FOCUS CHARTING
 SAMPLE
 DOE, SANDRA

Date/Hour	Focus	Patient Care Notes
4 -/90	Seclusion	D: Was received in seclusion from previous shift.
1020		Please refer to Special Notes of Nurse.
		A: Given a free trial period at 17.
		R: Seclusion terminated after free trial period
		but she refused to leave the seclusion room. She
		was allowed to leave and re-enter the room at
		liberty.
	Delusions of Jealousy	D: States, "Art is going to die and so are all the
		women who are sleeping with him". Says she is
		angry with "Art".
		A: Informed her that I was here for her, and would
		listen to her as long as her conversation did not
		center on accusations against "Art".
		R: Requested use of a quiet room so that she
		could read. <i>D. Smith</i>

Appendix C

Workbook for Training Staff to Improve the Documentation of Patient's Progress

**WORKBOOK FOR TRAINING STAFF TO IMPROVE THE
DOCUMENTATION OF PATIENT'S PROGRESS**

Written by

Sonia Acosta, M.A.

Edited by

Lenore Sauer, RN

Director of Nursing

April 1990

KRPH

STATEMENT OF PURPOSE

The purpose of this workbook and training session is to teach you how to improve documentation of patient's progress through the use of highly descriptive patient care notes that at the same time meet the standards set by the Joint Commission on the Accreditation of Hospitals, Health Care Finance Administration, and KRPB Nursing Department.

The standards that we have identified for quality progress notes are:

- 1.- Notes must be related to the patient's nursing care plan and/or staff observations.
- 2.- Patient behaviors must be described in observable rather than interpretive terms. **DATA**
- 3.- Notes must describe any actions taken by staff when dealing with the patient.

ACTION

- 4.- Notes must describe a patient's response to staff interventions. **RESPONSE**
- 5.- Notes must be signed by staff (signature should include first initial, last name, and professional title or discipline), and include date and time.
- 6.- Notes must be free of derogatory terms such as "brain-damaged" or "pesty".

We will review each standard and learn through the use of examples and non-examples and practice exercises.

STANDARD/QUESTION: 1. Is the patient care note related to the nursing care plan and/or staff observations?

RATIONALE: When we write a patient care note on a patient, we want to relate its content to the patient's treatment plan which includes behaviors described in the nursing care notes. This way, we are specifically responding to the progress made by the patient on the reasons for his/her hospitalization. If we describe how

much progress the patient has made on each goal, we will be better able to decide whether that specific goal has been achieved.

SITUATION 1:

NURSING FOCUS: Hostile and threatening verbalizations.

EXPECTED PATIENT OUTCOME: The patient will interact with others without becoming verbally threatening.

NON-EXAMPLE:

DATA: X has been cooperative and has not reported any complaints. He ate all his meals and took his medication.

EXAMPLE:

DATA: X does not talk much with others and he has not been threatening to them, or

D: X interacts with others when he is in the dayroom, he initiates conversation and he smiles when he is greeted.

EXPLANATION:

If we know that one of the patient's problems is that he threatens others when he gets upset, then we want to report any progress made in this area and not whether he has been eating all of his meals or taking his medication. These were not the problems that brought him to the hospital in the first place.

SITUATION 2:**NURSING FOCUS:** Paranoid delusions.**EXPECTED PATIENT OUTCOME:** Patient will state that he feels safe on the Unit and that he does not think that people are plotting against him.-----
NON-EXAMPLE:**D:** X has been pleasant, watched T.V. and did oral care with supervision.-----
EXAMPLE:**D:** X initiates greetings and jokes with others, he talks to others when he goes out on activities or on his ground permit,
or**D:** X does not respond to greetings and he says "Stay out of my way" when he is approached.-----
EXPLANATION:

If one of the patient's problems is that he does not trust others because he thinks that they are against him, then we want to report his behavior in this area. Writing that he has been watching T.V. or brushing his teeth does not give us information about how he is doing with respect to his 'paranoia'.

NOTES:

SKILL PRACTICE 1

INSTRUCTIONS: Read the following patient situations, then circle the progress notes that are related to the patient treatment goals (nursing care plan and/or staff observations) and cross the ones that are not.

Two of X treatment goals or expected outcomes are:

FOCUS: Hygiene and grooming.

- Pt. will wear clean clothes after taking a shower.

FOCUS: Activity participation.

- Pt. will participate in at least 3 activities per week (e.g., playing cards, pool, going bowling, van rides, etc.).

PROGRESS NOTES (DATA)

1. Pt. ate a full supper tray and snacks. He was cooperative with ward routine.
2. Pt. expressed no complaints, he ate well and interacted with others.
3. Pt. took a shower and changed clothes after several prompts.
4. Pt. has been seen smoking cigarette after cigarette. He has been quiet.
5. Pt. played pool with one of his peers, he was smiling and seemed to enjoy the game.
6. Pt. refused to shower and start swearing at staff. He was encouraged and finally took a shower. He wore clean clothes after much prompting.

NOTES:

SKILL PRACTICE 1 A

INSTRUCTIONS: Given the following treatment goals, write 2 separate patient care notes that will show how much progress the patient has been making.

TREATMENT GOALS/ EXPECTED PATIENT OUTCOMES:

1. Pt. will respond to greetings (e.g. "Hello", "Fine") and establish eye contact when spoken to.

2. Pt. will take his prescribed medication every day without arguing about whether he needs it or not.

STANDARD/QUESTION: 2. Are patient's behaviors described in observable terms? DATA

RATIONALE: Something is observable if it is possible to notice it (hear, taste, smell, touch, see, or feel) and if it is possible to examine it scientifically. Feelings such as depression or disappointment are usually only noticeable by the individual who is experiencing them. So, we are not going to use them for our descriptions unless they are accompanied by examples or better descriptions of the actual behaviors.

When we use adjectives such as friendly or withdrawn, we are not describing what are the behaviors we are actually observing but our interpretations which are quite variable from observer to observer.

----- < FOCUS: Social Withdrawal > -----

NON-EXAMPLE 1:

D: Pt. is friendly and pleasant. He shows a low profile and cooperates with unit routine.

EXAMPLE 1:

D: Pt. attended store party today. He responds to greetings and initiates conversations with others. OR

D: Pt. has been friendly, i.e., he smiles when greeted and interacts with others.

EXPLANATION:

When we use the terms "pleasant" or "friendly", we are not specifying what are the behaviors we are observing. These terms have different meaning for different people and we do not want to become judgemental.

=====

< **FOCUS: Delusions and Hallucinations** >**NON-EXAMPLE 2:**

D: Pt. shows bizarre behavior, he has been expressing many delusional ideations. He seems to be responding to internal stimuli.

EXAMPLE 2:

D: Pt. has been making several delusional statement such as, "I own millions of dollars and the state of New York",

or

D: Pt. has been mumbling to himself when no one else is around. At times, he even raises his tone of voice.

EXPLANATION:

If we are talking about delusions, we have to make sure that we give examples of what the patient is saying. Also, we have to make sure that these statements are not true. What do we mean by "internal stimuli"? Are we talking about physiological responses such as hunger or thirst? For our purposes, we are not using these terms which are rather confusing.

If we think that a patient is experiencing auditory hallucinations, then we should describe the behaviors that are indicating to us that this is the case. For example, we can describe whether the patient is moving his lips, mumbling, moving some parts of his body and talking at the same time, etc.

NOTE: We might want to make an effort in getting close to the patient and try to listen what he is saying when he is mumbling to himself and write it down. The content of these verbalization might have clinical value.

NOTES:

SKILL PRACTICE 2 A**INSTRUCTIONS:**

Read the following progress notes. Circle the ones which describe patient's behaviors in observable terms.

1. The patient takes pride in his personal appearance.
2. The patient has been pleasant and cooperative.
3. The patient ate all his meals today.
4. The patient responds appropriately when approached.
5. The patient paces the hall, looking at the floor and with a frown in his face.
6. The patient has been very delusional this evening.
7. The patient took a shower and changed into clean clothes.
8. The patient has been quiet, i.e., he has not been talking to others and he does not respond to greetings.
9. The patient has shown a low profile and has been grouchy.
10. The patient has been making several delusional statements, "Everyone here is against me, they want to kill me because I am a veteran" and "staff come into my room at night and torture me".
11. The patient was observed swinging his arms into the air and saying something that was hardly understandable when he was by himself.
12. The patient brushed his teeth and made his bed without staff reminders.
13. The patient was relating to internal stimuli. He looked worried.
14. The patient is very aggressive and is about ready to blow.
15. The patient spent all morning in his bed sleeping.

SKILL PRACTICE 2 B

INSTRUCTIONS: Write 3 brief notes (2-3 lines) in which patient's behavior is written in observable terms.

OBSERVABLE:

1.

2.

3.

LIST OF TERMS**OBSERVABLE TERMS**

-verbalize
-differentiate
-took a shower
-told his peer
-hit
-ate
-express
-scream
-smiled
-talking
-smoking
-refused
-cooperates with

NON-OBSERVABLE TERMS

-low profile
-internal stimuli
-low key
-internalizing
-relating to
-suspicious
-delusional
-bizarre
-loud
-evasive (without explanation)
-smoking safely
-hyper
-quiet

STANDARD/QUESTION: 3. Are actions taken by staff when dealing with the patient described? ACTION

RATIONALE: One of the ways we can demonstrate that we are providing treatment rather than custodial care is by describing what do we do when dealing with the patient. Our job is not merely observational, we have to show that we do intervene and provide the plan of action we described in the treatment plan.

NON-EXAMPLE 1:

Pt. voiced no complaints OR

Pt. got in a fight this morning. No further problems later on.

EXAMPLE 1:

DATA: Pt. was sitting in the dayroom by himself, looking at the floor with a frown in his face.

ACTION: Staff approached him and asked how he was doing. OR

DATA: Pt. was observed mumbling to himself and making movements with his hands as if talking with somebody when no one was present.

ACTION: Staff greeted him and asked if he wanted to play cards or needed to talk to someone.

EXPLANATION:

If we only write what we see and make no effort to make a change in the patient's environment, then we cannot say that we are providing treatment. Many times, we actually do something for the patient but we do not document our efforts. We must provide written evidence that we are following the patient's treatment plan.

Besides, if an observation or action is not charted, the presumption is that it was not done. While this does not prevent a nurse from testifying about uncharted information, the nurse's credibility may be easily attacked for attempting to recall certain events several weeks after the fact.

SKILL PRACTICE 3 A

INSTRUCTIONS: Read the following progress notes. Circle the ones which describe any **ACTIONS** taken by staff when dealing with the patient.

1. X has been talking so loudly to himself all morning, that it is starting to bother other patients. Pt. came for meals.
2. X has been having loud verbal outbursts when his needs are not met immediately. He was approached and offered an opportunity to express himself in a calm tone of voice when making his requests.
3. X has been spending too much time in his room. He only came out for meals and medication. He watched T.V.
4. X made his bed and took a shower after only one reminder. He has been relaxing and interacting with others.
5. X has been pacing the halls talking to himself. His attention was refocused by offering him alternative activities such as cards or a game of pool.
6. X is complaining about his diet and not having enough money. Staff listened to him but did not argue with him.
7. X is getting into an argument with Y and they are becoming angry with each other. Staff separated them and spoke with each individual separately.
8. X is refusing to take his medication. He was given a choice of taking it orally or taking it by injection.
9. X ate all his meals and brushed his teeth with staff supervision.
10. X has been spending almost all morning lying in bed. He was approached and encouraged to play pool or cards.

SKILL PRACTICE 3 B

Given the Data, write down some of the possible actions taken by staff.

- - -

DATA: The patient has been making delusional statements such as, "they have been putting marijuana in my cigarettes."

ACTION:

DATA: The patient has been spending all morning in his room. He only came out for meds.

ACTION:

DATA: The patient has been pacing the hall with his fists clenched and a frown on his face.

ACTION:

STANDARD/QUESTION: 4. Is the patient's response to staff interventions described? RESPONSE

RATIONALE: It is very difficult to evaluate the effectiveness of specific staff actions if we do not document whether the patient's response was favorable, did not make any difference or was detrimental. We need to document how effective our approach was for future reference.

NON-EXAMPLES :

ACTION: The patient was offered and accepted the use of the quiet room to calm down after he had a verbal outburst. OR

ACTION: The patient needed 3 reminders to take a shower.

= = = = = =

EXAMPLES:

D: The patient was constantly talking to himself when nobody was close to him.

A: Staff asked him if he wanted to join a checkers game.

R: The patient refused to participate and continued talking to himself.

OR

D: The patient has not taken a shower for four days and he is refusing to take one today also. He has a strong body odor.

A: Staff gave him a choice of getting in the shower by himself or having staff escort him to the shower room.

R: The patient chose to get in the shower by himself and took one with no further problems.

STANDARD/QUESTION: 5. Is the note free of derogatory terms?

RATIONALE: When people are referred to as "disabled", "pesty", "brain damaged" or "deaf and dumb", a picture of incapacity and inability is painted. The use of such terms is an insult and a disservice to the individual involved (Michigan Commission on Handicapper Concerns, 1988).

By focusing on a person's abilities and strengths rather than limitations, we can help change people's attitudes and take a more positive approach that will lead to rehabilitation.

NOTE: Avoid the use of terms such as "always" or "never" when describing a patient's behavior. These terms give an illusion of permanence to such behaviors and nurture the pessimistic belief that such behaviors are unchangeable.

NON-EXAMPLES:

D: Pt. has been as pesty today as he always is.

OR

D: Pt. is very obstinate, he does not want to sign the informed consent.

OR

D: Pt. is brain damaged so his mental capabilities are those of a retarded individual.

EXAMPLES:

D: Pt. has not been listening or following instructions this morning.

OR

D: Pt. refuses to sign the informed consent even after several attempts and explanations of its benefits.

OR

D: Pt. has had brain injuries and his learning abilities are limited.

ACCEPTED TERMS

- Person with a disability
- Person who has a mobility impairment, wheelchair-user
- Person who has had a stroke
- Person with mental illness or disability
Psychiatric disability
- Person with brain injury
- Person with mental retardation deficient
- Person who has epilepsy
- Person with learning disabilities
- Person who has a speech disorder, person without speech
- Seizure

INAPPROPRIATE TERMS

- Disabled person
- Crippled, restricted to a wheelchair
- Stroke victim
- Mental deviant or crazy, mentally deranged, former mental patient, insane
- Brain damaged
- Moron, mentally
- the epileptic
- Retard, lazy, not motivated, SPED
- Mute
- Fit or convulsion

STANDARD/QUESTION: 6. Is the note dated and signed by staff, i.e., does it include date, time, first initial, last name and title or discipline?

RATIONALE:

Some of the criteria for good documentation are that charting be timely. It is preferable when timing entries in the patient's chart to note the exact time the entry is made rather than the time the event occurred. This makes the patient's record legally more accurate. Another criterion for good documentation is writing legibly. Because one of the purposes of documentation is that of communication to others, that purpose can only be achieved if what is written can be read.

Remember, the patient's medical record is a legal record which can be used in a variety of legal proceedings. Besides, we want to be able to identify who wrote a specific note in case we want further details on the patient's behavior.

NON-EXAMPLES:

EXAMPLES:

MORE EXAMPLES ON FOCUS CHARTING

Date/Hour	FOCUS	PATIENT CARE NOTES
4/5/90 1030	Social withdrawal	D: Pt. has been lying in bed all morning. A: Staff encouraged him to come to the dayroom and play cards or watch T.V. R: Pt. stated "OK" and went and sat among his peers in the dayroom. OR R: Pt. did not answer to staff and remained in bed.
+ + + + + + + +		
4/8/90 1320	Hygiene and grooming	D: Pt. is walking around with his hair uncombed and his shirt untucked. A: Staff encouraged him to comb his hair and tuck his shirt. R: Pt. complied and smiled when he was praised. OR R: Pt. said, "Forget you" and walked away.
+ + + + + + + +		
4/12/90 1740	Verbal threats	D: Pt. is making verbal threats "I'm going to kill you if you keep bothering me" A: Staff encouraged him to go to his room to calm down but he refused. He was offered the quiet room. R: Pt. accepted and came out after 10 minutes. He was not threatening any more. A: Staff praised him for calming down on his own. R: Pt. smiled.

DATE/HOUR	FOCUS	PATIENT CARE NOTES
4/25/90 0930	Verbal outbursts	D: X has been friendly polite while interacting with others. He made few positive comments in community meeting today. No verbal outbursts noted. A: Staff praised him for his comments. R: X smiled and said "Thanks".

+ + + + + + + +

4/4/90 1345	Unsafe smoking habits	D: X has been smoking in the dayroom. He dropping cigarette ashes on the floor. A: He was redirected to use an ashtray while smoking. R: X complied. OR R: X complied after swearing at staff.
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SKILL PRACTICE 6 A

DATE/HOUR	FOCUS	PATIENT CARE NOTES
4/8/90 1430	Paranoid delusions	D:

◦

Appendix D
Social Validation Questionnaire

Social Validation Questionnaire

Please fill this questionnaire out and return it to me by 5:00 pm today.

Answer the following questions and write a brief explanation when pertinent.

Eighty percent of the staff were surveyed.

Thirty two surveys were handed out with 100 percent return.

1. Were the training sessions a good use of your time?

Yes	No
-----	----

96.87%	3.12%
--------	-------

Describe:

"very helpful, it helped me document more accurately"

"helped me understand and cleared up points"

"clarified focus charting"

2. Was the workbook helpful in clarifying situations discussed during training?

Yes	No
-----	----

100%	0%
------	----

Describe:

"well done"

"very helpful"

3. Were the examples given in the workbook helpful in writing your notes?

Yes	No
-----	----

100%	0%
------	----

Describe:

4. Are you using some of the suggested examples when writing your notes?

Yes	No	Sometimes
-----	----	-----------

65.62%	3.12%	31.25%
--------	-------	--------

Describe:

"I like the word action list"

5. Is it more difficult to write progress notes following the new standards?

Yes	No
31.25%	59.37

Describe:

Three staff members did not answer this question.

Comments were:

"You have to know the patient and their charts"

"I have to think harder and that takes time"

6. Does it save time to write progress notes following the standards discussed?

Yes	No	Same
37.5%	25%	31.25%

Describe:

One staff did not answer and another answered "sometimes"

7. Do you have a better understanding now of what it is expected from you when writing progress notes?

Yes	No	Same
68.75%	9.37%	15.62%

8. Do you think that you meet progress notes standards better after you received training?

Yes	No
90.62%	9.37%

9. Does using what you have learned on these sessions have an impact in your interactions with the patients?

Yes	No
34.37%	65.62%

How?

"some things are more planned out"

"talk more with the patients"

"interaction is more frequent"

10. Do you think that other staff will read your notes more often now that you are using the new standards?

Yes	No	Same
9.37%	46.87%	37.5%

Describe:

"I know I read others' more"
 "I don't know, information is easier to access"

11. Do you think that patients will get better evaluations of progress when using these standards?

Yes	No	Same
53.12%	31.25%	12.5%

Describe:

12. Is there a better way of evaluating patients' progress other than progress notes?

Yes	No
12.5%	56.25%

Describe:

Ten staff did not answer this question and one stated "maybe"
 "actual time on the unit with the patient"

Question 13 was only given to the group that received feedback.

13. Was the weekly feedback (i.e., graphs) useful in clarifying any of your questions?

Yes	No
83.33%	16.66%

How?

"gave us an idea on how well we were doing"
 "able to ask instructor questions that clarified problem areas"
 "I think individual feedback would have helped better"
 "I felt very good about myself and other staff when we saw the graph consistently reach 95%....I overheard many favorable comments like "wow, aren't we great!"

Appendix E

Forms

RELIABILITY FORM

UNIT: _____ PATIENT CODE: _____

INDICATORS	DATE	REL.	DATE	REL.	DATE	REL.	DATE	REL.	DATE	REL.	DATE	REL.
1. Are prog. notes related to nursing care plans?												
2. Are pt. behaviors described in observable terms?												
3. Are actions taken by staff described?												
4. Are pts' response to staff intervention described?												
5. Are notes free of derogatory terms?												
6. Are notes properly signed and dated?												
7. Are all DAR categories correct?												

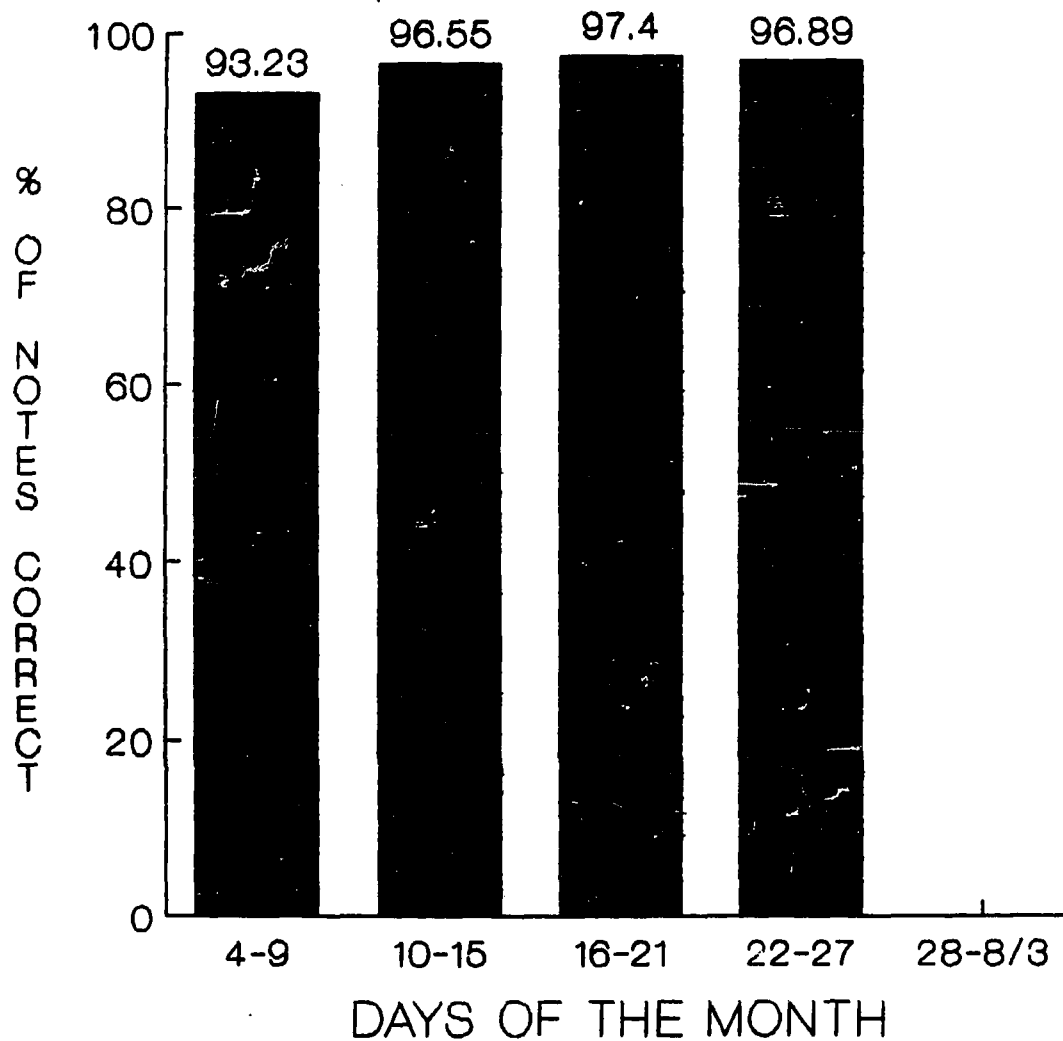
TOT A: _____ TOT D: _____

Appendix F

Example of a Weekly Feedback Graph

UNIT 2

JULY PM SHIFT



Great Job !

- You are remembering to write down dates and time.
- Remember to specify what the patient is doing. Do not write terms such as preoccupied or seclusive without a description of the behavior. Also, if he did not do something, write down what did you see him doing.

Appendix G
Human Subjects Review Proposal and Approval Letter

WESTERN MICHIGAN UNIVERSITY

Date: February 16, 1990

To: Maria Sonia Acosta

From: Mary Anne Bunda, Chair *Mary Anne Bunda*

This letter will serve as confirmation that your research protocol, "Improving the Documentation of Patient's Progress in a Mental Health Facility Through the Use of Training and Feedback", has been approved under the exempt category of review by the HSIRB. The conditions and duration of this approval are specified in the Policies of Western Michigan University. You may now begin to implement the research as described in the approval application.

You must seek reapproval for any changes in this design. You must also seek reapproval if the project extends beyond the termination date.

The Board wishes you success in the pursuit of your research goals.

xc: P. Mountjoy, Psychology

HSIRB Project Number 89-09-17

Approval Termination February 16, 1991

ABSTRACT: Briefly describe the purpose, research design, and site of the proposed research activity.

PURPOSE: To provide training and evaluate a performance feedback system for staff on three continuing care units of the Kalamazoo Regional Psychiatric Hospital (KRPB). The goal is to increase correspondence between the content of progress notes and the patient's treatment plan and to meet existing standards set forth by the Joint Commission on Accreditation of Hospitals (JCAH), Health Care Finance Administration (HCFA), and KRPB Nursing Department.

RESEARCH DESIGN: A multiple baseline design across groups, with time of introduction of the conditions varying for the three units will be used. Training will be provided to staff on unit 1 and then after two weeks, training will be provided to staff on unit 2; then, three weeks later training will be provided to staff on unit 3.

Feedback in the form of group graphs and verbal feedback will be provided weekly after training has taken place. Feedback won't be given to unit 3.

CONDITIONS

BASELINE: Progress notes will be scored before implementing any changes in the current system.

TRAINING: Staff will be required to attend 2 one-hour training sessions. They will use a workbook especially designed to teach how to write progress notes according to KRPB standards. Staff will be told that this is a project to evaluate the training being required for nursing staff at Kalamazoo Regional Psychiatric Hospital on writing progress notes.

FEEDBACK: Graphs depicting the percentage of successful performance on daily progress notes standards will be posted on units 1 & 2 on a weekly basis. In addition, each staff member will receive a copy of the graph. Only performance data for a specific unit will be posted on that unit. Besides these graphs, the researcher will meet with nursing staff on a weekly basis for approximately 10 minutes to discuss any deficiencies on the progress notes written for a specific week.

FOLLOW-UP: After four months of providing feedback, staff will be told that no more graphs will be provided, but that data will still be collected. This follow-up condition will be in effect for two months.

SITE: This study will be conducted at Kalamazoo Regional Psychiatric Hospital using data generated from progress notes of nursing staff working on three continuing care units.

BENEFITS OF RESEARCH: Briefly describe the expected benefits of the research.

1. To increase correspondence between the content of progress notes and patient's treatment plan and to meet requirements established by the Joint Commission on Accreditation of Hospitals, HCFA, and KRPH Nursing Department.

2. To provide data to hospital administration which will assist in the evaluation of training provided to nursing staff.

3. To provide hospital staff with objective and measurable data on patient's

progress that will aid in the decision-making process relative to whether or not the patient needs further hospitalization.

CHARACTERISTICS OF SUBJECTS: Briefly describe the subject population (e.g., age, sex, prisoners, people in mental institutions, etc.). Also indicate the source of subjects.

Staff including 13 registered nurses, 4 licensed practical nurses, and 27 residential care aides will participate in the study. Of these, 20 are females and 24 are males.

All are assigned full time to one of three continuing care units at KRPB for the morning (6:30 am to 3:00 pm) or evening (3:00 pm to 11:00 pm) shifts or from 8:00 am to 5:00 pm.

SUBJECT SELECTION: How will the subjects be selected? Approximately how many subjects will be involved in the research?

The three continuing care units were selected on the basis of access to patient's records by the researcher. The total number of individuals involved in the study will be 44.

RISKS TO SUBJECTS: Briefly describe the nature and likelihood of possible risks (e.g., physical, psychological, social) as a result of participation in the research.

None; no individual data can be identified. Staff must write progress notes as part of their job requirements and these notes must be reviewed and evaluated as part of hospital quality assurance guidelines. This study simply enhances this task.

PROTECTION FOR SUBJECTS: Briefly describe measures taken to protect subjects from possible risks, if any.

No staff person will be individually identified. All data will be presented as percentage of successful group performance. All feedback will be positive and no negative consequences will be delivered for poor performance.

CONFIDENTIALITY OF DATA: Briefly describe the precautions that will be taken to ensure the privacy of subjects and confidentiality of information. Be explicit if data is sensitive.

1. All identifying information will be deleted from copies of the progress notes by a graduate assistant (not the researcher) employed by KRPH before the researcher and other assistants come into contact with the progress notes. This includes the patient names and staff names.

2. Each progress note copy will be assigned a letter (code) by the graduate assistant. She will use this code to allow the researcher to group the progress notes by unit for data analysis.

3. Once coded and scored, the progress notes copies will be destroyed.

4. The graduate assistant who deletes the identifying information will not be further involved in this research project.

5. Individual data will not be used; there will be no means of identifying the author of any progress note.

6. All data generated at KRPH is a part of hospital records. However, these data will not become part of an individual's employee records and will not be used for hospital performance appraisals, raises, promotions or demotions.

QUESTIONNAIRES OR INTERVIEW SCHEDULES: If questionnaires, interview schedules or data collection instruments are used, please identify them and attach a copy of what will be used in the project.

Social validation form (see enclosed sheet).

INFORMED CONSENT: Attach a copy of the informed consent and assent (if applicable). Each subject should also be given a copy.

Not applicable. Training will be mandatory.

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