nursing care evaluation

Concurrent and retrospective review criteria

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NURSING CARE EVALUATION

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PREFACE

With the enactment of Public Law 92-603, the Professional Standards Review Organization (PSRO) was established, with its primary purpose being to provide quality assurance programs that will attain the highest degree of excellence in the delivery of health care. The PSROs membership is comprised of doctors of medicine and osteopathy, and the organizational direction is toward medical quality assurance. The major program components include admission certification, continued stay review, medical care evaluation studies, and profile analysis. A great deal of time and financial assistance were expended to develop medical screening criteria to assist in the program's implementation.

It is unrealistic to believe that a legally mandated quality assurance program would not have a far-reaching effect on other members of the health team and particularly on the practice of nursing. However, the profession of nursing has addressed the current modifications in practice in a positive manner, without benefit of funding sources, without mass education of its practitioners in the implementation and regulations of PSRO, and without adequate nursing research. There has been some confusion throughout the country concerning nursing quality assurance programs because of a lack of understanding about PSRO regulations and the Joint Commission on the Accreditation of Hospitals (JCAH) audit requirements, a lack in uniformity of approaches, a lack of common nomenclature, and, most importantly, a lack of substantial norms, standards, and criteria guides. *Nursing Care Evaluation: Concurrent and Retrospective Review Criteria* addresses these concerns and provides guidelines by which the profession of nursing can move forward in its involvement with PSRO activities.

The introductory section discusses the implications of PSROs in the health care setting and explores the expected role of the nurse in the organizational framework. A comprehensive overview of quality assurance is included, which emphasizes nursing care evaluation and its major components. The purposes and objectives of concurrent and retrospective review are defined, and the methodology for criteria development is analyzed. Examples of nursing care evaluation formats are presented with explanations for their modification and implementation.

The model nursing criteria sets are arranged in alphabetical order for quick reference. The nursing criteria amplify and extend physician's criteria by providing for psychosocial needs, patient education, discharge planning, adaptation to health status, retrospective criteria, and critical nursing management for complications, which is frequently initiated

before medical management of complications. Both concurrent and retrospective review criteria have been developed for over 250 major diseases and medical conditions, and the criteria sets are referenced to established systems of coding (HICDA, Hospital International Classification of Diseases adapted for use; ICDA-8, International Classification of Diseases Adapted for Use; and DSM-II, Diagnostic and Statistical Manual of Mental Disorders, Vol. 2). Numerical designations are included to indicate which diagnoses apply to a particular criteria set. Coding each criteria set in this manner will be useful in coordinating the model nursing criteria with the medical criteria and in identifying exactly which criteria sets apply to which diagnostic entities.

In addition, a glossary of pertinent terms specifically pertaining to PSRO is included in Appendix B.

This book is written primarily for those nurses and nurse administrators who are involved in PSRO, by providing guidelines for the development and implementation of audit criteria. However, these comprehensive criteria can also be used by staff nurses making clinical assessments, as a guideline in identifying a patient's physical or psychological needs and concerns; and by team leaders and primary nurses, as a learning tool for making clinical observations, writing nursing care plans, and evaluating their own performances.

The audit methods presented in this book are not to be considered the "last word" in or the "best methods" of nursing care evaluation but rather are to serve as an alternative approach to present nursing care evaluation programs or to be modified and revised to meet the needs of each individual hospital, health care institution, or PSRO organization. It is hoped that this book will stimulate the evaluation of existing programs and will move the profession of nursing forward in the evolutionary process of determining appropriate, cost effective, efficient quality assurance for nursing that is compatible with the Professional Standards Review Organizations and improved nursing care.

We would like to acknowledge the efforts of many nurses throughout the country who assisted us in determining and analyzing the "state of the art" in their individual hospitals. In particular, we would like to extend our sincere thanks to Lucille Ashley, Diane Baker, Suzanne Dziak, and Dianne Goodspeed, whose assistance in planning the methods developed in this book have been invaluable.

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SECTION ONE

Introduction

PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS

Overview

Many forces have influenced the current thrust for quality assurance within the total spectrum of the health care delivery system. Court decisions charging physicians, hospitals, nurses, or nursing services with inadequate care, negligence, and even malpractice have reached alarming proportions. The voice of the consumer, once a murmur, is growing stronger in expressing dissatisfaction with the health care system. Within the nursing profession, organizations such as the American Nurses' Association have made recurring statements attempting to identify the nurses' responsibilities for monitoring the quality of care and services. The release of standards for practice in the major clinical areas attests to the profession's recognition of its responsibility to society. The most recent revisions of standards for accreditation by the Joint Commission on Accreditation of Hospitals (JCAH) requires that hospitals demonstrate an effective method for assessing the quality of care provided to patients. Certainly, the major force for quality care has been the formalization of quality assurance programs in health care, mandated in Public Law 92-603—the 1972 amendments to the Social Security Act—which provided for the creation of Professional Standards Review Organizations (PSROs).

The PSRO is a program organized, administered, and controlled by local physicians and osteopaths to evaluate the necessity for and quality of medical care delivered in their designated areas under Medicare, Medicaid, and Maternal Child Health Programs. The organization of PSROs is based on the "concept that health professionals are the most appropriate individuals to evaluate the quality of medical services and that effective peer review at the local level is the soundest method for assuring the appropriate use of health care resources and facilities."*

PSRO legislation was enacted because there were compelling arguments for such a law. As one physician spokesman stated, "PSRO is here because of failures in the system in the past. Those failures are the major reasons why quality of care in this country is spotty and why, in the Medicare and Medicaid programs, much abuse and misutilization occurred, with its resultant, serious inflation of health care costs."†

A PSRO manual containing the initial information and procedural materials needed for implementation of the provisions of the law relating to professional standards review has been prepared by the staff of the Bureau of Quality Assurance. It has been designed to accommodate new or supplemental material as further interpretations of the law and changes in procedures are made.

PSROs utilize the guidelines included in this manual as the base for their programs. A summary of PSRO review responsibilities appearing in the manual includes:

1. Professional Standards Review Organizations will review the health care provided under Medicare, Medicaid and Maternal and Child Health Programs and make judgements on the medical necessity and quality of care. In addition, PSROs will determine whether care is proposed to be provided or has been provided at a level of care that is most economical and consistent with the patient's medical care needs.
2. PSROs are required over a period of time, to perform review of the care provided in institutions (for example, short-stay general hospitals, tuberculosis hospitals, mental health hospitals, skilled nursing facilities, and intermediate care facilities). A PSRO may review non-insti-

*Report of the Committee on Finance United States Senate, U.S. Government Printing Office, Washington, D.C., Sept. 26, 1972, p. 265.

†Simmons, Henry, Nov. 7, 1973.

tutional care if it requests to do so and if the Secretary of the Department of Health, Education, and Welfare approves such a request.

3. Initially, PSROs should, at a minimum, establish a system for review of care provided to inpatients in short-stay general hospitals and develop a phased plan for the performance review in long-term care facilities. If it demonstrates capability in these areas, the PSRO may develop review systems for care provided in other institutions and for non-institutional care.
4. For review in short-stay hospitals, the PSRO will be required at a minimum to perform (A) admission certification concurrent with the patient's admission, (B) continued stay review, and (C) medical care evaluation studies. As the capability progresses in its area to develop profiles, the PSRO will be required to review these. The PSRO will develop criteria and standards and select norms for each type of review which it performs . . . (note: alternate approaches developed by applicant PSROs will be reviewed and may be found acceptable providing they have the potential to result in the establishment and operation of an equally or more effective review system than that outlined in the manual).
5. PSROs are required to utilize the services and adopt the findings of review committee(s) of hospitals which in the judgment of the PSRO, are capable of performing review effectively . . .
6. The PSRO will work closely with Medicare, Medicaid and Maternal and Child Health Administrative and fiscal agents in the development, implementation and operation of its review program . . .*

The nurse's role in the PSRO

Nurses are included in the PSRO as non-physician health care practitioners. The PSRO Program Manual emphasizes that the Professional Standards Review Organizations are expected, over a period of time, to provide evidence that non-physician health care practitioners are involved in the following activities:

1. Development and ongoing modification of norms, criteria, and standards for their areas of practice
2. Development of review mechanisms to be used for peer assessment of the performance of non-physician health care practitioners
3. Conduct of health care review of non-physician health care practitioners by their peers
4. Working with established continuing education programs to assure utilization of results of review in educational efforts
5. Where appropriate, participation by both physicians and non-physician health care practitioners in review committee activities

Professional nurses also have other mechanisms for input into the organization. The guidelines permit inclusion of non-physicians on the governing body of the PSRO, but they are not eligible to vote on issues relating to the physician practice of medicine and osteopathy. Advisory groups are to be established to assist each state Professional Standards Review Council or PSRO in states without councils. The advisory groups are to include representatives from the non-physician health care professions within the PSRO area.

In evaluating the status of PSRO organizations, it was determined that little or no activity was being directed toward the non-physician health care practitioners (especially nurses). Local nursing groups have experienced difficulty in implementing programs that comply with the regulations set forth by the PSROs. Factors impeding progress in this area are a lack of financial resources, limited knowledge of legislative regulations, non-availability of reference materials for education, and inadequate nursing research in quality assurance. As a result, local nursing groups have been left with a piecemeal grouping of norms, standards,

*P.S.R.O. *program manual*, Office of Professional Standards Review, U.S. Department of Health, Education, and Welfare, Mar. 1974, pp. 1-3.

and criteria and the development, in various parts of the country, of specialized, limited approaches that are not comprehensive enough to meet the needs of individual health care institutions and PSRO programs.

In order to comply with the PSRO regulations, local nursing groups will have to develop norms, criteria, and standards for their areas of practice and must agree on the definitions of these terms. For the purpose of this discussion, norms, standards, and criteria are defined as follows: (1) norms are numerical or statistical measures of usual observed performances; (2) standards are professionally developed expressions of the range of acceptable variation from a norm or criteria; (3) criteria are predetermined elements against which aspects of the quality of a medical service or nursing service can be measured.

Confusion during physician and nurse review activities will be minimized when both groups adopt the same terminology.

NURSING QUALITY ASSURANCE

Nursing quality assurance can be defined as a commitment to excellence in the delivery of health care. It is a program designed to determine the extent to which a specific nursing practice achieves selected objectives (criteria) based on specified values (norms). These specified values are then measured in terms of predetermined standards. Analysis of data collected exposes deficiencies or variations in nursing care. Continuing education programs can then be implemented to correct these variations and upgrade professional performance. Reevaluation will reveal the change in professional behavior instituted through nonpunitive, educational measures. The overall effectiveness of the nursing quality assurance program and the identification of review priorities will be realized through profile analysis.

With the current legislative interest and an increase in available literature about nursing quality assurance, one might think that this is a new concept. However, the concept of quality control in nursing care is not new to nurses. When it is analyzed, the Nightingale Pledge attests to quality—and most professional nurses have made public proclamation to support the pledge. Among the earliest efforts to assess adequacy of medical and nursing care and its impact on recipients can be found in *Notes on Matters Affecting the Health, Efficiency and Hospital Administration of the British Army* by Florence Nightingale. Published in 1858, this work included comparing mortality experience in the British armed forces during the Crimean War with experience in civilian populations. This work forcefully brought to the attention of the government and the public the atrocious standards of care for military personnel. Although by today's standards the data are crude, the report was, nevertheless, instrumental in bringing about basic reforms in living standards and health services for the British armed forces.

In the past, quality assurance consisted primarily of hospital environmental and organizational standards. It was also assumed that if a nurse met certain educational requirements for licensure quality nursing care would naturally follow. Today, quality assurance considers not only environmental, organizational, and educational factors, but also focuses attention on the impact of nursing care on the patient. At one time or another all nurses have been involved in a "checklist" that evaluates room temperature, cleanliness, safety, medication given promptly, and the utilization of the nursing staff. These situations deal with certainties—either one did or did not perform. Nursing has the current responsibility of teaching nurses, especially staff nurses, to deal with probabilities or outcomes, nursing priorities on a concurrent basis, identification of patterns of nursing care based upon validated crite-