

**CHAPTER 6. VA CENTRAL OFFICE NURSING SERVICE REPORTING REQUIREMENTS**

**6.01 STATEMENT OF POLICY**

Specified reports are required to maintain a coordinated Nursing Service and to facilitate the strategic management processes of Central Office Nursing Service.

**6.02 GENERAL PROVISIONS**

Nursing Service information will be forwarded within the facility as appropriate for computer entry in accordance with medical center policies and procedures.

**6.03 REPORT OF QUALIFICATIONS OF NURSES, RCS 10-0016 (OLD RCS 10-147)**

a. VA Form 10-5349, Professional Career Development Information (Physicians, Dentists and Nurses--Selected Positions) and VA Form 10-5349a, Professional Career Development Information (Nursing Supplement), will be completed annually by incumbents of centralized positions and nurses with a master's degree or higher degree. These forms will be updated throughout the year when career plans or qualifications change.

b. VA Form 10-5349a will be completed by all recipients of a VA Health Professional Scholarship at the time of appointment or upon completion of the scholarship program, and annually until obligated service is completed.

**6.04 REPORT OF NURSING SERVICE, RCS 10-0034 (OLD RCS 10-220)**

VA Forms 10-1106 and 10-1106a (AMIS), Nursing Service Code Sheet Manhours Worked by Nursing Personnel, will be prepared in accordance with VA policy and procedures.

**6.05 NURSING SERVICE ANNUAL REPORT, RCS 10-0654 (PREVIOUSLY IDENTIFIED AS NURSING PROGRAM REPORT, RCS 10-0034 AND OLD RCS 10-220)**

VA Form 10-9003, Nursing Service Annual Report, will be prepared annually as of September 30. It will provide information about the preceding fiscal year. The original and one copy will be forwarded through the appropriate Regional Director (10BA\_\_/118) and is due in Central Office by the 10th workday in October.

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#### CLASSIFICATION OF PATIENTS ACCORDING TO THEIR NURSING CARE NEEDS

This appendix provides instructions for health care facilities to classify medical/surgical patients, extended care patients, critical care patients, psychiatric patients and spinal cord injury patients. The category in psychiatric patients excludes patients in drug and alcohol units. The methodologies are based on the classification of patients according to their nursing care requirements, related to patient dependency and amount of direct nursing care provided.

The purpose of the classification system is to determine the number of patients classified into each of several categories, depending on the clinical area, that represent requirements for nursing care and serve as a measure of staffing needs. (See MP-6, part VI, Supplement No. 1.2.) Each of the classification systems is briefly described below:

The Medical/Surgical Patient Classification System is used on Medical/Surgical Units. Spinal Cord Injury Units are excluded. This system classifies patients into four categories ranging from minimal nursing care (Category I) to more intensive nursing care (Category IV). VA Form 10-0005, Patient Classification Form, dated August 1981 is used to record information.

*The Extended Care Patient Classification System* is used on Intermediate Medicine and Nursing Home Care Units only. This classification system has three categories which range from minimal nursing care (Category I) to extensive/complete nursing care (Category III). Use VA Form 10-0005a, Nursing Patient Classification Form - Extended Care, dated May 1985.

*The Critical Care Patient Classification System* is used in critical care units only, i.e., Medical Intensive Care Units, Surgical Intensive Care Units, Coronary Care Units, and combinations of these. All other types of units are excluded. Specifically excluded are "step down" and "telemetry units." This classification system classifies patients into three categories which range from minimal nursing care (Category I) to extensive/complete nursing care (Category III). Use VA Form 10-0005b, Nursing Patient Classification Form - Critical Care, dated May 1985.

*The Psychiatric Patient Classification System* is used on Psychiatric Units only. Drug and Alcohol Units are excluded. This system classifies patients into four categories ranging from minimal nursing care (Category I) to extensive/complete nursing care (Category IV). Use VA Form 10-0005c, Nursing Psychiatric Patient Classification Form, dated January 1986.

[The Spinal Cord Injury Patient Classification System is used on Spinal Cord Injury Units only. This system classifies patients into five categories

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ranging from minimal nursing care (Category I) to extensive/critical (Category V). Use VA Form 10-0005d, Nursing Spinal Cord Injury Patient Classification Form, dated January 1989.]

These classification systems have been fully tested and validated. Instructions have been developed and effective application of the methodology will depend upon proper classification of the patient. A suggested procedure to ensure inter-rater reliability of 90 percent or better is described at the end of the appendix.

The Nursing Service of each medical center will classify patients daily. The appropriate patient classification form will be used for each patient depending on the clinical area. Patient identification information should be placed on the form and placed with the Nursing Care Plan (such as a Kardex). The patient will be assigned a category

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which best identifies individual nursing care needs using definitions provided for each classification system. Newly admitted patients will be classified upon admission. A registered nurse will classify assigned patients on a daily basis and the category of each patient will be verified at 3 p.m. every day by the head nurse or designee. After familiarity with the classification system, this procedure should be accomplished in a matter of seconds. The classifier should be a registered nurse who knows the patient. A second registered nurse should periodically sample and evaluate the classification process. Data should be reported according to the AMIS instructions.

**INSTRUCTIONS AND DEFINITIONS FOR VA FORM 10-0005,  
PATIENT CLASSIFICATION FORM (MEDICAL/SURGICAL)**

The following are a set of definitions and some examples of VA Form 10-0005. Categories range from I (minimal care) to IV (intensive care).

- a. Patient identification information, unit, and date are entered at the top.
- b. Clinical indicators are selected that appropriately describe the patient and marked by entering checks in all the horizontal white boxes/parentheses on the appropriate lines.
- c. Add the checks in each column, downward. Preexisting fixed weight checks in columns I and II and the pre-weight of .5 in column III should be included in the count when adding the columns. Enter the sum of each column in the row marked "Total." The column with the highest total determines the patient's category. If the columns have the same total, the higher classification is noted. The appropriate category number at the top of the column is circled.
- d. The "Comments" space is used to record a special situation which justifies a higher category than indicated by the total. For example, a patient in isolation, smoking hazard, or a wanderer.
- e. The following definitions are to be used in completing the form:

**Items Indicating Needs for Care      Definitions**

- |                          |  |
|--------------------------|--|
| (1) Activity Independent | Checked if patient takes own bath (basin at bedside, tub, or shower) with minimal supervision; manages own personal hygiene even if on maintenance IV, catheter, etc.; moves from bed without help. This item should not be checked if any of the following items (2) through (6) are checked. |
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- |                               |   |
|-------------------------------|---|
| (2) Bath, Partial Assist      | Patient can start own bath, but not complete it. Needs help to get to shower or tub, and/or supervision and encouragement during bath. If patient needs help only to wash back, this item should not be checked; if patient requires complete bed bath, it should not be checked. |
| (3) Position, Partial Assist  | Patient can assist in turning or positioning in bed; cannot move independently from bed to chair. Needs help in maintaining proper alignment (e.g., traction, foot board).  |
| (4) Position, Complete Assist | Needs complete assistance in turning, position, and propping in bed or chair. This items also assumes patient cannot help with own bath. Only "Partial" or "Complete Assist" should be checked, not both.   |

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Items Indicating Needs for Care	Definitions
(5) Diet, Partial Assist	Can feed self after help in opening cartons, cutting meat, etc. May require supervision and encouragement to eat.
(6) Diet, Feed	Must be fed, or may need constant supervision and encouragement due to swallowing difficulty. Gastric gavage or gastrostomy tube feeding. Only "Partial Assist" or "Feed" should be checked, not both.
(7) IV additive every 6 hours	IV TKO (to be kept open) which requires frequent monitoring may be checked here even if patient is independently active.
(8) Observe every 1 to 2 hours	Requires symptom observation and monitoring over and above IV checks and every 2 to 4 hours vital signs, e.g., hourly output, 15-minute neurological checks, vital signs until stable after surgery or diagnostic procedure.
(9) Observe, Almost Constant	In addition to the above, requires almost constant observation due to special equipment, complex treatments and/or problems. Only one or the other of the "observe" items should be checked. If a patient requires constant observation, this fact, in most instances, will classify the patient as class IV regardless of the number of checks in each column.

The following are two case presentations used as examples:

Mr. S.                    2/14/86  
Soc. Sec. No            6W 62-4W

**MEDICAL/SURGICAL--CASE NO. 1:**

Mr. S., 63-year-old bilateral above the knee amputee, admitted to surgical unit with abdominal pain status post ileo resection with ileostomy and mucous fistula (Post-op day Number 6).

Vital signs q8h; daily weight. Requires close observation due to dehydration and weakness (at least q2-3h); is on a low sodium diet;

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requires constant encouragement to take fluids and nourishment; feeds self.

NS with Potassium via IV-requires close observation and frequent repositioning of arm to maintain rate and patency.

Up in chair-must be observed. Wet to dry abdominal dressing q8h.

Trach, ileostomy care; depressed and needs much encouragement.

Bathes self.

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Mr. J. 2/14/86  
Soc. Sec. No. 2W, 216

**MEDICAL/SURGICAL--CASE NO. 2:**

Mr. J., 67-year-old patient on a medical unit with COPD and tracheostomy.

Unresponsive and requires total care.

VS q4h; I and O; turn q2h; water mattress; special skin care; up in chair q day;

Range of Motion tid.

External catheter; incontinent.

Tracheostomy care q8h with frequent suctioning (at least q1h); 26 percent O2 with mist via T-tube; Arterial/Blood gases qd.

Continuous tube feeding-check residual q8h.

Pilonidal cyst requires irrigation 1/2 strength peroxide q8h.

Continuous IV fluids; IV meds.

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**INSTRUCTIONS AND DEFINITIONS FOR VA FORM 10-0005b,  
PATIENT CLASSIFICATION FORM - CRITICAL CARE**

The following are a set of definitions and some examples of the Critical Care Patient Classification System. Categories include minimal care (I), moderate care (II), and extensive or complete care patients (III):

a. Patient information, unit, and date are entered at the top.

b. Clinical indicators are selected that appropriately describe the patient and marked by entering checks in parentheses on the appropriate lines. If the line has two sets of parentheses, these are both checked. The section labeled "Physiological Monitoring" requires one entry. If "Position Complete" is marked, the checks are placed in both sets of parentheses. The other patient care indicators are marked only as appropriate, e.g., if a patient is on room air and receiving no specific respiratory care, there would be no checks in the section labeled "Respiratory Status."

c. The number of checks in each column are totaled and entered on the appropriate lines. The fixed weight in Category II is to be included in the total.

d. The highest total of checks determines the patient category. If columns have the same total, the higher category is used. The appropriate category number at the top of the columns is circled.

e. The "Comments" space is used to record a special situation which justifies a higher category than indicated by the total. No explanation is needed for a Category III when "Special Procedures" is marked.

f. The following definitions are to be used in completing the form:

**Items Indicating Needs for Care      Definitions**

**(1) Position**

(a) Partial Assist                      Independent or needs partial assistance with ADL, coughing, and deep breathing.

(b) Complete Assist                    Needs complete assistance with ADL and positioning, ROM, thermia units, special frames, circle beds, etc.

**(2) Physiological Monitoring**

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At intervals of:  
More than 2 hours  
1 to 2 hours  
1 hour or less

Observation of body functions (temperature, blood pressure, heart function, etc.), including use of procedures or apparatuses for detecting and preventing problems.

**(3) Intravenous Therapy**

(a) IV

TKO; maintenance, Heparin lock; additive q4-6h.

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**Items Indicating Needs for Care      Definitions**

(b) IV--2 or more lines  
(Hemodynamic monitoring)

Multiple intravenous additives; blood; hyper-alimentation; hemodynamic/pressure monitoring.

**(4) Respiratory Status**

(a) Non-Acute

Oxygen therapy; few changes with ventilator settings; arterial lines; ventilator dependent; pulmonary toilet q4-q8h; treatments q4h.

(b) Acute

Weaning; frequent pulmonary toileting (q1-2h); frequent endotracheal suctioning; unstable respiratory status; intubation; frequent ventilator changes.

**5) Special Procedures**

These patients may require a 2:1 staff/patient ratio. May include such procedures as Blakemore tubes, cardioversion, insertion of pacemakers, intracranial pressure monitoring, extensive burn care, pericardiocentesis, circulatory or respiratory arrest, intra-aortic balloon pump, peritoneal dialysis, hemodialysis. A check on this line is automatically a Category III.

The following are three case presentations used as examples.

**MICU--CASE NO. 1:**

Mr. Brown, 58 years old, has been a patient in the MICU for the past 5 days and was admitted for Upper GI Bleeding. Bleeding was controlled with iced saline lavage and drug therapy. The patient also received multiple blood transfusions. Condition is now stable. Cardiac monitoring and IV has been discontinued; vital signs are taken every 4 hours. Mr. Brown needs assistance with all activities and will be transferred to a general medical unit this morning.

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**SICU--CASE NO. 2:**

Mr. Johnson was admitted to the SICU from the RR following a cholecystectomy. Patient had a myocardial infarction 8 months ago. During the operative procedure, Mr. Johnson had an episode of ventricular tachycardia with hypotension. The situation responded favorable to Lidocaine. The patient now has occasional PVC's. Vital signs are B/P 134/94, P-84 NSR, R-20. Mr. Johnson was extubated in the OR and is now on continuous O2 via face mask. A nasogastric tube and foley catheter are in place. Mr. Johnson's orders include vital signs and rhythm strips every hour. The patient has two peripheral IV's.

**CCU--CASES NO. 3:**

Mr. Jones age 58 was admitted to CCU with severe chest pain radiating to the left arm. Assessment revealed BP 90/60, AHR 58, Resp. 22. EKG showed an irregular heart rate. Skin was cool, clammy and diaphoretic. A Swan-Ganz catheter was inserted and PAWP and vital signs are monitored every 30 minutes. Two hours after admission, Mr. Jones' BP dropped to 60/? AHR 32. Vasopressors were started, IV and a demand pacer was inserted. Mr. Jones suffered acute respiratory failure, was intubated and placed on a ventilator. Mr. Jones' condition continues to deteriorate and preparations have begun for insertion of an IABP.

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**INSTRUCTIONS AND DEFINITIONS FOR VA FORM 10-0005a,  
PATIENT CLASSIFICATION FORM - EXTENDED CARE**

The following are a set of definitions and some examples of the Extended Care Patient Classification System. Categories range from minimal nursing care (I) to extensive/complete nursing care (III):

- a. Patient information, unit, and date are entered at the top.
- b. Items in each of the five major areas are checked that best describes the patient's needs. Only one item should be checked for each major care area. For example, if in the area of basic hygiene, a patient needs to be bathed completely by nursing staff, "Complete Assist" is checked.
- c. The number of checks in each column are added vertically and then entered in the row marked "Total" under the appropriate column. The column with the greatest number of checks is the patient's classification.
- d. The appropriate category should be circled at the bottom of the form. If there is a tie, the higher category is circled.
- e. The following definitions are to be used in completing the form:

**Areas Indicating Needs for Care    Definitions**

**(1) Basic Hygiene/Bathing**

- |                     |   |
|---------------------|---|
| (a) Self            | Patient needs no help or supervision.   |
| (b) Partial Assist  | Patient can start own bath but cannot complete it. May need help to get into shower or tub, supervision or encouragement during bath, or assistance to dress. |
| (c) Complete Assist | Must be bathed, showered and dressed (does not participate).  |

**(2) Nutrition/ Feeding**

- |                    |   |
|--------------------|---|
| (a) Self           | Patient needs no help or supervision.   |
| (b) Partial Assist | Can feed self after cartons are opened and food is cut. May require supervision and encouragement to eat. |

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(c) Complete Assist

Must be fed totally by another person; or may need constant supervision and encouragement due to swallowing difficulties, resistiveness. Include gastric gavage; tube feedings.

(3) **Elimination**

(a) Self

Patient is continent and does not have accidents or takes care of ostomy, catheter, or related device by self.

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Areas Indicating Needs for Care	Definitions
(b) Assist	Requires assistance with bedpan or urinal; or receives help in care of ostomy, catheter or related device. May include a scheduled bowel or bladder program.
(c) Incontinent	Has inadequate control of bladder or bowels (regardless of staff intervention) requiring complete assistance/incontinent care at least once per shift.
<b>(4) Mobility</b>	
(a) Self	Patient transfers, walks or wheels self without assistance or supervision.
(b) Partial Assist	Needs some assistance or supervision in transferring, walking or wheeling.
(c) Complete Assist	Needs complete assistance (does not participate) in transferring; is wheeled or bed confined. Requires help in positioning and maintaining proper alignment (i.e., traction, footboards).
<b>(5) Behavior/Orientation</b>	
(a) Alert, Oriented, Responsive	Patient is oriented to time, place, person. No disruptive behavior problems.
(b) Occasionally Disoriented, Confused	Disoriented in one or two spheres (time, place, person); may have alternative periods of awareness/unawareness; may exhibit some disruptive behavior, i.e., disrobing, screaming, wandering into unacceptable places.
(c) Disoriented, Combative, Unresponsive	Is disoriented in all three spheres (time, place, person), or is unresponsive or exhibits resistive, striking out, or aggressive behavior to a degree that there is impairment in the performance of basic activities of daily living.

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The following are two case presentations used as examples:

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**EXTENDED CARE--CASE NO. 1:**

Mr. G. is an 80-year-old male with post partial bowel resection 2 months and a secondary diagnosis of degenerative joint disease. Bowel sounds are present and patient tolerates regular diet well. Due to limited ROM, Mr. G. needs assistance with setting up food tray, bathing and dressing. Mr. G. ambulates with a walker and maintains bathroom privileges with assistance. Mr. G. ambulates TID, is up in a chair for 1 hour TID, and has VS q8h.

**EXTENDED CARE--CASE NO. 2:**

Ms. M. is a 72-year-old female admitted for a right pelvic fracture which occurred 4 months ago. Ms. M. was transferred from the surgical unit. Secondary diagnoses include insulin controlled diabetes mellitus, hypertension and arthritis. Patient is blind and has some loss of hearing and is edentulous, and cannot tolerate oral intake. Continual enteral nutrition support via Keofeed tube is needed to prevent further weight loss. Due to pelvic immobilization, arthritis, and generalized weakness, Ms. M. requires complete assistance with ADL's. Patient experiences transient disorientation at night which requires placement of protective devices.

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**INSTRUCTIONS AND DEFINITIONS FOR VA FORM 10-0005c,  
NURSING PSYCHIATRIC PATIENT CLASSIFICATION FORM**

The following are a set of definitions and some examples of VA Form 10-0005c categories ranging from minimal care (I) to extensive nursing care (IV).

- a. Patient identification information, unit, and date are entered at top of form.
- b. Patient care indicators are marked by entering checks in parentheses on appropriate lines. If the line has multiple parentheses, check them all.
- c. The indicator that best describes the patients care needs is checked in each of the five major areas. Only one indicator should be checked for each major care area. For example: Unit Privileges--if a patient may leave the unit alone, only this indicator should be checked. When checking an indicator, all brackets [ ] must be checked horizontally for that indicator.
- d. The number of checks in each column is totaled and entered on the appropriate lines. Always include the fixed weight count in Categories I, II, and III.
- e. The column with the highest total determines the patient's category. The appropriate category number at the top of the column is circled.
- f. The "Comments" space is used to record a special situation which justifies a higher category than indicated by the total. For example, a patient requiring complex dressings.
- g. The following definitions are to be used in completing the form.

**Areas Indicating Needs for Care    Definitions**

**(1) Observation/Intervention**

- |             |  |
|-------------|--|
| (a) Routine | Requires observation of specific symptoms or conditions (b) 15-25 Min/Hr. that would require nursing to observe patient over and (c) 30-45 Min/Hr. above routine rounds. Includes vital signs, neuro checks, (d) Constant color, patient orientation and/or combativeness. The appropriate criteria should be checked according to the time listed. Also included in the criterion is the amount of time required on an interpersonal level. |
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**(2) Unit Privileges**

- |                           |   |
|---------------------------|---|
| (a) May leave unit alone  | Check, if patient has a pass or permission to leave unit unaccompanied.         |
| (b) Out with staff/family | Check, if patient has off unit privileges with family, staff members or others. |
| (c) Restricted to unit    | Check, if patient has no pass or is not allowed off unit to attend groups.      |
| (d) Restricted to room    | Check, if patient is restricted to room or is in seclusion.                     |

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**Areas Indicating Needs for Care      Definitions**

**(3) Restraint Application**

- (a) No                                      Check yes, for patient who requires application of leather/plastic restraints.
- (b) Yes                                      Check no, if it does not apply.

**(4) Incontinent of Bowel/Bladder**

- (a) No                                      Check yes, for patient who is actively incontinent of urine or feces. Also applies to patients with extreme diaphoresis. Does not need to be marked if patient has indwelling catheter.
- (b) Yes                                      Check no, if it does not apply.

**(5) One to One Restriction**

- (a) No                                      Check yes, if patient requires constant nursing supervision during the entire shift, (e.g., suicide precautions).
- (b) Yes                                      Check no, if it does not apply.

The following are three case presentations used as examples.

**PSYCHIATRIC--CASE NO. 1:**

Mr. J., 47 years old, was admitted 2 weeks ago with Post-traumatic Stress Disorder. Patient has been attending group therapy on a daily basis. Mr.J. needs minimal supervision from the nursing staff and is motivated to follow treatment plan. Mr. J. is involved with Social Service for job retraining and placement.

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**PSYCHIATRIC--CASE NO. 2:**

Mr. P. is a 52-year-old who was admitted with a diagnosis of Undifferentiated Schizophrenia. He is hospitalized for medication reevaluation. He attends unit activities and is fairly cooperative. At times, is delusional in conversations with peers and staff. Patient is only allowed to go off the unit with a staff or family member.

**PSYCHIATRIC--CASE NO. 3:**

Mr. S., 76 years old, was admitted 2 days ago with a diagnosis of Alzheimer's Disease. Patient is disoriented x3. Mr. S. requires complete assistance with ADL's and is incontinent of urine. Nursing staff interact frequently with Mr. S., for reality orientation. Patient is restricted to the unit as Mr. S. wanders and gets lost.

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**SUGGESTED PROCEDURE TO ENSURE INTER-RATER RELIABILITY AMONG NURSES IN  
CLASSIFYING PATIENTS USING VA PATIENT CLASSIFICATION METHODOLOGIES**

**Why Is Inter-Rater Reliability Important?**

The determination of workload and nurse staffing requirements are dependent on accurate classification of patients. Inter-rater reliability is a method to establish and maintain consistency in the way nurses classify patients both within an individual nursing unit and among all similar units at each medical center.

In order to check on the internal consistency of the patient classification system, an evaluation of inter-rater reliability must be conducted. Since accurate assessments of patient classification are an integral component in the determination of required nursing hours, the reliability of the patient classification process should be evaluated periodically and corrective measures should be taken when indicated as part of an ongoing program.

**Purpose and Scope.**

The purpose of this procedure is to measure and minimize variability in the way different nurse raters classify the same kinds of patients using a VA patient classification system. The procedure is directed at achieving a high level of consistency in patient classification or inter-rater reliability within a health care facility. Efforts to measure and attain high inter-rater reliability among different medical centers within the VA health care system may be taken at a later date.

**Who Should Perform This Function?**

The success of the patient classification system and the evaluation of inter-rater reliability is dependent upon knowledge of the system and a commitment to it by each nurse who is involved. A registered nurse, designated by the Chief, Nursing Service, should be assigned the overall responsibility to evaluate levels of inter-rater reliability. The nurse assigned this responsibility may be in either a staff role or a management position. This determination should be based on the organization structure of the Nursing Service and availability of resources. Nurses who should be considered are Nursing Instructors, Clinical Nurse Specialists, Nursing Supervisors, and Head Nurses.

Two additional nurses, designated by the Chief, Nursing Service, should be assigned to assist the nurse who is responsible for this project. Assistants should have a thorough knowledge and demonstrate competence in the nursing care requirements of patients in a selected area and in the patient classification

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system. These nurses should also demonstrate consistency in the manner in which they classify patients.

**Process**

This approach is based on evaluating the consistency of patient classification among nurses, and working with individual nursing units until acceptable levels of consistency are achieved. A reduced frequency of review is then performed to ensure continued high levels of reliable patient classification.

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The proposed frequency and scope for evaluating consistency is outlined below:

a. Concentrate efforts to achieve acceptable consistency on one unit at a time. Work with that unit only until the goal of 90 percent consistency is reached, then move to the next unit.

b. The evaluating nurses should classify 15 patients on the nursing unit every day until 90 percent consistency is achieved. Consistency, in this instance, will mean that nurses on the unit are following the established procedure for classifying patients, and that there is agreement between the evaluating nurse and the unit nurses in the classification assigned to each patient.

c. The evaluating nurse should classify patients without prior consultation with nurses on the unit.

d. Corrective measures should be taken immediately after an evaluation when consistency is found to be less than 90 percent. This should be done in a helpful and instructive manner with the nursing unit staff. Immediate feedback to the Head Nurse is recommended. The participation of the Head Nurse is essential in efforts to clarify points of confusion and to achieve greater consistency.

e. After a unit has achieved 90 percent consistency, plan to evaluate it again at the end of 1 month to ensure that 90 percent consistency is maintained. If classification consistency falls below 90 percent, continue a more intensive review until problems are corrected.

f. When a nursing unit has maintained 90 percent consistency at the end-of-month review, plan to review the unit every 3 months thereafter.

g. Nursing unit personnel should not know in advance when a review is to be performed.

**Guidelines To Aid Reviewer:**

(a) A data collection form should be prepared which contains 10 sample patient classification cards on an 8 1/2 x 11 sheet of paper.

(b) Each nurse reviewer will be assigned to a specific unit. To maintain objectivity the reviewer should not be assigned to their own unit.

(c) The reviewer will independently classify patients. This process may include:

Review of the nursing care plan

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Review of the patient's chart

Direct patient observation

(d) Continue until all 15 patients have been classified.

(e) Compare patient classification results obtained through the independent review with the results of the same 15 patients classified by the unit. In reviewing the unit's classification results, it is important to check the accuracy and completeness of the classification forms done by the individual unit. This includes checks on addition and correct procedures in marking the form.

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(f) Identify inconsistencies between results of the classification done on the unit and the reviewer's results on the data collection form. Discuss these with the Head Nurse or Nurse in Charge.

(g) Provide further comments on the data collection sheet, as appropriate for each discrepancy, noting whether the variation is justified based on additional information or is considered to be unjustified.

(h) Results should be entered on a summary report for each unit. A sample report illustrating the format is shown:

**Inter-Rater Reliability Summary Report**

**Psychiatric Patient Classification System**

		Number of Classifications		Percentage
Unit	Date of Review	With Agreement	Without Agreement	of Consistency
4A	2/15/86	12	3	80

Comments:

Example: 15 patients were reviewed and classified. There was inter-rate agreement on 12 patients. Therefore, the percentage of consistency was 12 divided 15, which is 80 percent.

Results of the reviews provide a valuable management tool in directing educational and other resources to areas where problems may exist. This information also provides a method to determine the status of the implementation of the patient classification system and the reliability of the data within each Nursing Service.

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**INSTRUCTIONS AND DEFINITIONS FOR VA FORM 10-0005d,  
NURSING SPINAL CORD INJURY PATIENT CLASSIFICATION FORM**

The following are a set of definitions and some examples of VA Form 10-0005d (categories range from I (Minimal Care) to V (Extensive/Critical)):

- a. The patient's name, bed number, unit and date are entered at the top of the form.
- b. Those items/factors which best describe a given patient are checked in all columns in the corresponding row for the items. For example, if Bowel Care, Complete Assist, is marked, you should have checks in the brackets in columns three and four.
- c. If you check Activity Independent, you must not check any other indicator.
- d. Only one of the monitor categories may be checked.
- e. If you check any of the monitor/observe/teach indicators there must be some type of intervention being done for the patient in the time frames indicated.
- f. Total the number of checks in each column and enter the totals on the appropriate lines. Always include the FIXED WEIGHT count in Categories I, II, and III. The category should be circled at the top of the form.
- g. The column with the highest total determines the patient's category. The appropriate category number at the top of the column is circled. Should a tie occur the patient should receive the higher category.
- h. Use the "Comments" space to record a special situation which justifies a higher category than indicated by the total. For example, a patient requiring strict isolation.
- i. A check in column five under constant monitoring will automatically make the patient a Category 5.
- j. The following definitions are to be used in completing the form.

AREAS INDICATING NEEDS FOR CARE

DEFINITIONS

1. **ACTIVITY, INDEPENDENT** Checked if patient takes own bath/shower at bedside or bathroom. Must transfer self without help. This item should not be checked if any of the following items, number (2) through (9), are checked.
2. **BATH/SHOWER-Set-up,** Patient can begin own bath after set-up. Needs help to  
Stand by or Partial get to shower or tub, and supervision and  
Assist encouragement during bath. May need some verbal cues and either stand by or partial assist. Do not check if needs total bath with complete assist.
3. **BATH/SHOWER** Is dependent in bathing/showering or the patient may  
Complete Assist require so much guidance and cues that the bath/shower requires as much time as a complete assist. Do not check both (2) and (3).
4. **POSITION/TRANSFER** Patient cannot move independently from bed to  
Set-up, Stand by or wheelchair or toilet but can assist with  
Partial Assist positioning /transferring. Patient may be able to do activity after set-up of chair, bed, etc. Will need help with proper alignment after positioning or transferring.
5. **POSITIONING/TRANSFER** Is dependent in transferring/positioning or the  
Complete Assist patient may require so much guidance and cues that the positioning/transferring requires as much time as a complete assist. Do or not check both (4) and (5).
6. **DIET-Set-up** Patient must be set-up for meals either with of  
Stand by or Partial adaptive  
Assist devices or without them, must be supervised through the meal or must require partial assistance in eating.

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7. **DIET-Complete Assist** Patient must be assisted with most of diet or is totalling dependent in eating.
8. **BOWEL CARE** Patient must require assistance in establishing a bowel care program and in carrying out the activities of the program,  
Set-up, Stand by or either by set-up or stand by.  
Partial Assist
9. **BOWEL CARE** Patient requires assistance in most of the tasks around the bowl care program and cannot consistently assist with own program  
Complete Assist
10. **MONITOR/OBSERVE/TEACH** 15-25 Min./Hr. Patient requires nursing intervention with teaching, monitoring and/or observing for 15-25 minutes per hour.

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11. **MONITOR/OBSERVE/TEACH** Patient requires nursing intervention with teaching, monitoring and/or observing for 30-45 minutes per hour.  
30-45 Min./Hr.
12. **CONSTANT MONITORING** Patient requires constant monitoring or interventions because of special equipment or medical problems. (i.e., 1:1 staffing).

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The following are case presentations used as examples.

**EXAMPLE 1**

Mr. Smith is a 50 year old veteran with an incomplete injury of L5. Mr. Smith returned to the facility for his yearly checkup. Mr. Smith is able to do all activities of daily living and transfer. Mr. Smith needs minimal emotional support and teaching.

**NURSING  
SPINAL CORD INJURY  
PATIENT CLASSIFICATION FORM**

NAME Mr. Smith UNIT 1-A DATE 10/1/87

PATIENT CLASSIFICATION	I	II	III	IV	V
<b>ACTIVITY, INDEPENDENT</b>	(X)				
<b>BATH/SHOWER</b> -Set-up, Stand by or Partial Assist		( )	( )		
<b>BATH/SHOWER</b> -Complete Assist			( )	( )	
<b>POSITION/TRANSFER</b> -Set-up, Stand by or Partial Assist		( )	( )		
<b>POSITION/TRANSFER</b> Complete Assist			( )	( )	
<b>DIET</b> -Set-up, Stand by or Partial Assist		( )	( )		
<b>DIET</b> -Complete Assist			( )	( )	
<b>BOWEL CARE</b> -Set-up, Stand by or Partial Assist		( )	( )		
<b>BOWEL CARE</b> -Complete Assist			( )	( )	
<b>MONITOR/OBSERVE/TEACH</b> 15-25 Min/Hr.			( )	( )	
<b>MONITOR/OBSERVE/TEACH</b> 30-45 Min/Hr.				( )	

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CONSTANT MONITORING

( )

FIXED WEIGHTS	(X )	(X )	.5		
TOTAL	2	1	.5	0	0
COMMENTS					

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**EXAMPLE 2**

Mrs. Smith, a 48 year old patient with a fracture of C5-6, has returned to the facility because of a urinary tract infection. Mrs. Smith is able to shower unassisted but needs assistance in setting up the equipment for bowel care and meals. Mrs. Smith has been placed on antibiotics and is undergoing further bladder function exams.

**NURSING  
SPINAL CORD INJURY  
PATIENT CLASSIFICATION FORM**

NAME Mrs. Smith UNIT 1-A DATE 10/1/87

PATIENT CLASSIFICATION	I	II	III	IV	V
<b>ACTIVITY, INDEPENDENT</b>	( )				
<b>BATH/SHOWER</b> -Set-up, Stand by or Partial Assist		( )	( )		
<b>BATH/SHOWER</b> -Complete Assist			( )	( )	
<b>POSITION/TRANSFER</b> -Set-up, Stand by or Partial Assist		( )	( )		
<b>POSITION/TRANSFER</b> Complete Assist			( )	( )	
<b>DIET</b> -Set-up, Stand by or Partial Assist		(X)	(X)		
<b>DIET</b> -Complete Assist			( )	( )	
<b>BOWEL CARE</b> -Set-up, Stand by or Partial Assist		(X)	(X)		
<b>BOWEL CARE</b> -Complete Assist			( )	( )	
<b>MONITOR/OBSERVE/TEACH</b> 15-25 Min/Hr.			( )	( )	
<b>MONITOR/OBSERVE/TEACH</b> 30-45 Min/Hr.				( )	

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CONSTANT MONITORING

( )

FIXED WEIGHTS	(X)	(X)	.5		
TOTAL	1	3	2.5	0	0
COMMENTS					

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EXAMPLE 3

Mr. Jackson is a 33 year old veteran with a C3-4 fracture who was injured in an automobile accident. Mr. Jackson needs complete assistance with transfer and bowel care. Mr. Jackson has an IV with multiple additives. The monitoring of IV's and multiple additives plus teaching requires the staff to spend 15 minutes per hour with Mr. Jackson.

NURSING  
SPINAL CORD INJURY  
PATIENT CLASSIFICATION FORM

NAME	UNIT	DATE					
Mr. Jackson	1-A	10/1/87					
PATIENT CLASSIFICATION	I	II	III	IV	V		
<b>ACTIVITY, INDEPENDENT</b>	( )						
<b>BATH/SHOWER</b> -Set-up, Stand by or Partial Assist		( )	( )				
<b>BATH/SHOWER</b> -Complete Assist			( )	( )			
<b>POSITION/TRANSFER</b> -Set-up, Stand by or Partial Assist		( )	( )				
<b>POSITION/TRANSFER</b> Complete Assist			(X)	(X)			
<b>DIET</b> -Set-up, Stand by or Partial Assist		( )	( )				
<b>DIET</b> -Complete Assist			( )	( )			
<b>BOWEL CARE</b> -Set-up, Stand by or Partial Assist		( )	( )				
<b>BOWEL CARE</b> -Complete Assist			(X)	(X)			
<b>MONITOR/OBSERVE/TEACH</b> 15-25 Min/Hr.			(X)	(X)			
<b>MONITOR/OBSERVE/TEACH</b> 30-45 Min/Hr.					( )		

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CONSTANT MONITORING

( )

FIXED WEIGHTS	(X)	(X)	.5		
TOTAL	1	1	3.5	3	0

COMMENTS

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**EXAMPLE 4**

Mr. Peters, a 20 year old veteran with a C3-4 fracture, was admitted 2 months ago following a diving accident. Mr. Peters is experiencing severe emotional trauma due to his injury. Mr. Peters needs complete assistance with activities of daily living, meals and bowel care. Recently weaned from a respirator, Mr. Peters needs two, 10-minute respiratory assessment per hour. Mr. Peters is very hostile and abusive to staff and requires at least three, 5-minute staff interactions per hour.

**NURSING  
SPINAL CORD INJURY  
PATIENT CLASSIFICATION FORM**

NAME Mr. Peters UNIT 1-A DATE 10/1/87

PATIENT CLASSIFICATION	I	II	III	IV	V
<b>ACTIVITY, INDEPENDENT</b>	( )				
<b>BATH/SHOWER</b> -Set-up, Stand by or Partial Assist		( )	( )		
<b>BATH/SHOWER</b> -Complete Assist			(X)	(X)	
<b>POSITION/TRANSFER</b> -Set-up, Stand by or Partial Assist		( )	( )		
<b>POSITION/TRANSFER</b> Complete Assist			(X)	(X)	
<b>DIET</b> -Set-up, Stand by or Partial Assist		( )	( )		
<b>DIET</b> -Complete Assist			(X)	(X)	
<b>BOWEL CARE</b> -Set-up, Stand by or Partial Assist		( )	( )		
<b>BOWEL CARE</b> -Complete Assist			(X)	(X)	
<b>MONITOR/OBSERVE/TEACH</b> 15-25 Min/Hr.			( )	( )	

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MONITOR/OBSERVE/TEACH  
30-45 Min/Hr.

(X)

CONSTANT MONITORING

( )

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FIXED WEIGHTS	(X)	(X)	.5		
TOTAL	1	1	4.5	5	0

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COMMENTS

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EXAMPLE 5

Mr. Vicarelli is a 25 year old male with a fractured T4 who was injured in a motorcycle accident. Mr. Vicarelli was transferred to this facility on a respirator due to a pneumothorax. Mr. Vicarelli has one chest tube and multiple rib fractures. Mr. Vicarelli has IV's with multiple additives and must be turned every hour due to large decubitus ulcers on his coccyx. Due to excessive bronchial secretions, Mr. Vicarelli must be suctioned for 40 minutes per hour. Mr. Vicarelli is on hyperalimentation. Hourly outputs are being measured to assess kidney function. 1:1 staffing is required due to the monitoring and interventions needed by Mr. Vicarelli.

NURSING  
SPINAL CORD INJURY  
PATIENT CLASSIFICATION FORM

NAME <u>Mr. Vicarelli</u>	UNIT <u>1-A</u>	DATE <u>10/1/87</u>			
PATIENT CLASSIFICATION	I	II	III	IV	V
<b>ACTIVITY, INDEPENDENT</b>	( )				
<b>BATH/SHOWER</b> -Set-up, Stand by or Partial Assist		( )	( )		
<b>BATH/SHOWER</b> -Complete Assist			( )	( )	
<b>POSITION/TRANSFER</b> -Set-up, Stand by or Partial Assist		( )	( )		
<b>POSITION/TRANSFER</b> Complete Assist			(X)	(X)	
<b>DIET</b> -Set-up, Stand by or Partial Assist		( )	( )		
<b>DIET</b> -Complete Assist			(X)	(X)	
<b>BOWEL CARE</b> -Set-up, Stand by or Partial Assist		( )	( )		
<b>BOWEL CARE</b> -Complete Assist			(X)	(X)	
<b>MONITOR/OBSERVE/TEACH</b> 15-25 Min/Hr.			( )	( )	

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MONITOR/OBSERVE/TEACH  
30-45 Min/Hr.

( )

CONSTANT MONITORING

(X)

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FIXED WEIGHTS	(X)	(X)	.5		
TOTAL	1	1	3.5	3	1

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COMMENTS

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