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A Windows program to assist in preparing reports of emergency psychiatry nursing assessments

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The Emergency Psychiatry Nursing Assessment Report Framework (EP Nurse) is designed to guide the nurse through the interview-and-reporting process, and to produce a report of the nursing evaluation in emergency psychiatry in 5–10 min. Input includes identifying information, presenting complaints, substance-use history, medical history and vitals, psychiatric medications, treatment history, history of mental illness, last hospitalization, family history of mental illness, nursing diagnosis, and nursing intervention. EP Nurse is intended to be used by licensed nurses familiar with nursing assessment in emergency psychiatry. It is suitable for adult patients.

Beginning with a desire to improve our documentation while protecting staff time, we decided to program a report generator which would ensure a consistent organization and presentation of information, would assist nurses in more quickly producing reports, and would reduce the burden on the psychiatrists by creating printed reports for them to refer to before examining patients themselves. Prior experience with such a program for reporting the results of psychological evaluations had demonstrated the feasability of this approach (Tanner, 1993).

We selected the nursing assessment for the development of a report generator because nurses are the first to see the patients when they arrive in our busy emergency psychiatry service. The nurse's report not only documents our initial contact with the patient, but ideally provides information for the psychiatrists and social workers to use later during the patient's stay.

The nursing staff had already developed a form to use for their evaluations, and this was the starting point of the Emergency Psychiatry Nursing Assessment Report Framework (EP Nurse). We then alternated between incorporating suggestions from medical and nursing staffs and presenting the revised contents to key staff until we reached agreement on the data fields to be included. Once agreement was obtained for the fields, screens were designed and shared with the staff; the process was then repeated until agreement was reached on the screens and the resulting output.

The program is organized around 10 screens or views, similar to the paper forms which a nurse might complete. The user may proceed through the views in the suggested order, for example, moving from identifying information to substance-use history, or may follow whatever sequence of views they wish. The user can move through the data fields in a given view in any sequence and is able to skip fields that may not be pertinent for a particular patient, without leaving obvious gaps in the printed report.

The program begins with the Main View (see Figure 1). The nurse clicks on the view menu at the top of the screen, which drops down a list of the nine data views. Once the information has been entered on a data view (see Figure 2), the user clicks on the <OK> button at the bottom of the view to accept it. The nurse can move forward and back by clicking on the Next and Back buttons, much as one would move about with a VCR. Most reports will begin with Identifying Information 1 and 2, which collect demographic data. Identifying Information 2 also captures the presenting complaint. The nurse will then generally enter information about the patient's substance-use history. The patient's medical history and vitals are typically entered next, followed by information on psychiatric medications taken by the patient. The patient's treatment history, history of mental illness, last hospitalization, and family history of mental illness are also recorded. The last data view collects the nursing diagnoses and intervention. Clicking on <Main> returns the user to the Main View.

Some items are context sensitive. For example, if the nurse indicates that the patient is currently taking an antiasthmatic, but has not identified the patient as asthmatic, a warning message box is displayed. Similarly, if values outside of hospital-prescribed limits are entered for any vital sign, a warning message box is presented. Text scrolls to allow more input than will fit within the dimensions of the boxes.

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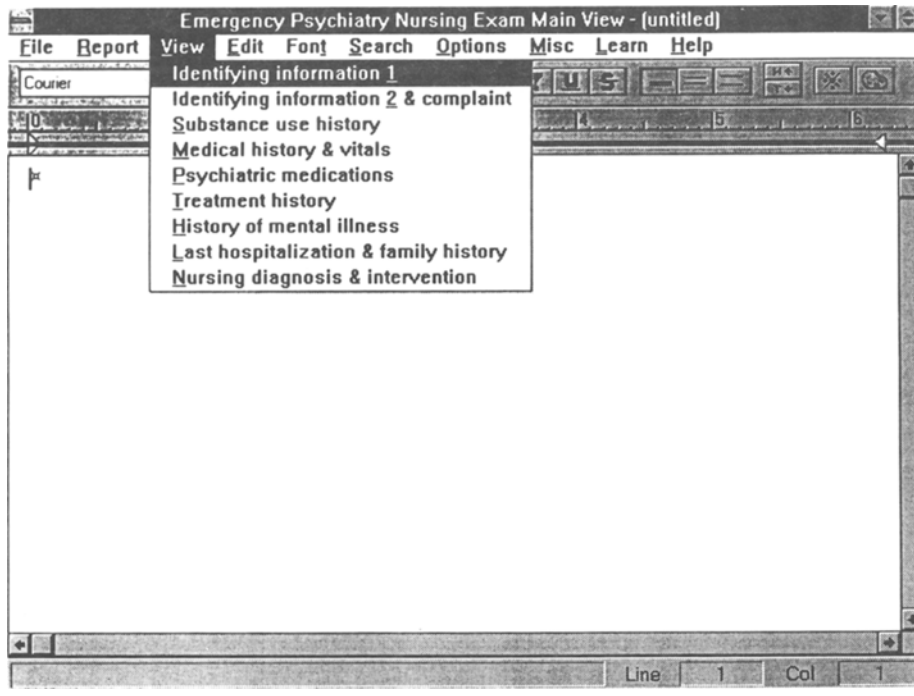

Figure 1. The Main View with the view menu down.

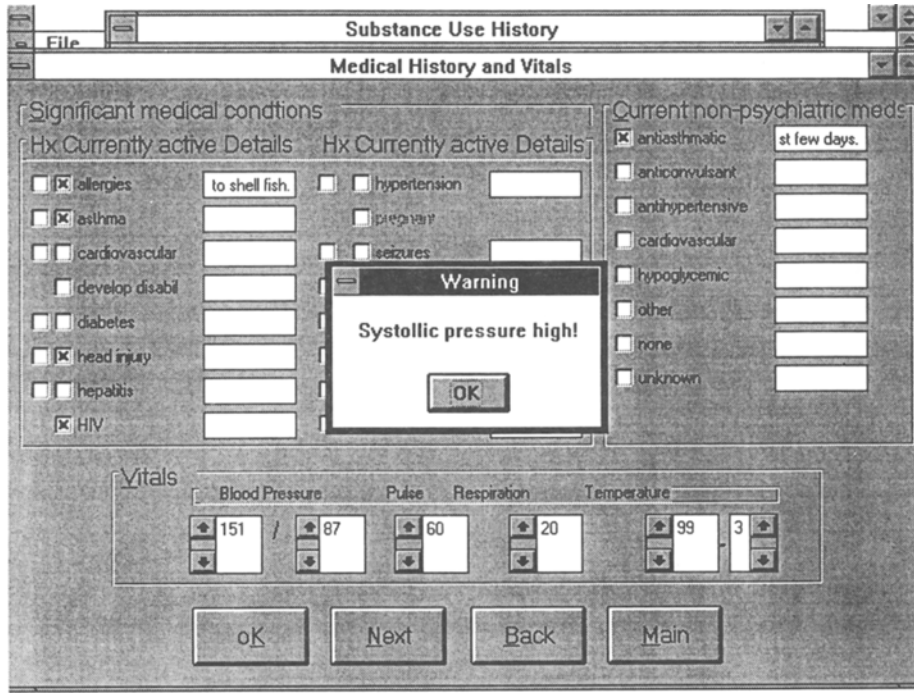

Figure 2. The Medical History and Vitals View with a warning message box.

Clicking <Report> at the top of the Main View produces a report that incorporates the information just entered (see Figure 3). That report may be edited and printed within EP Nurse and saved to disk. EP Nurse provides considerable text processing capabilities, as well as the option of saving the file in formats that can be read by many commercial word processors.

EP Nurse was written in Visual Basic 3.0, and uses HighEdit 1.10, a custom control, to provide word-processing capability. The program requires Windows 3.0

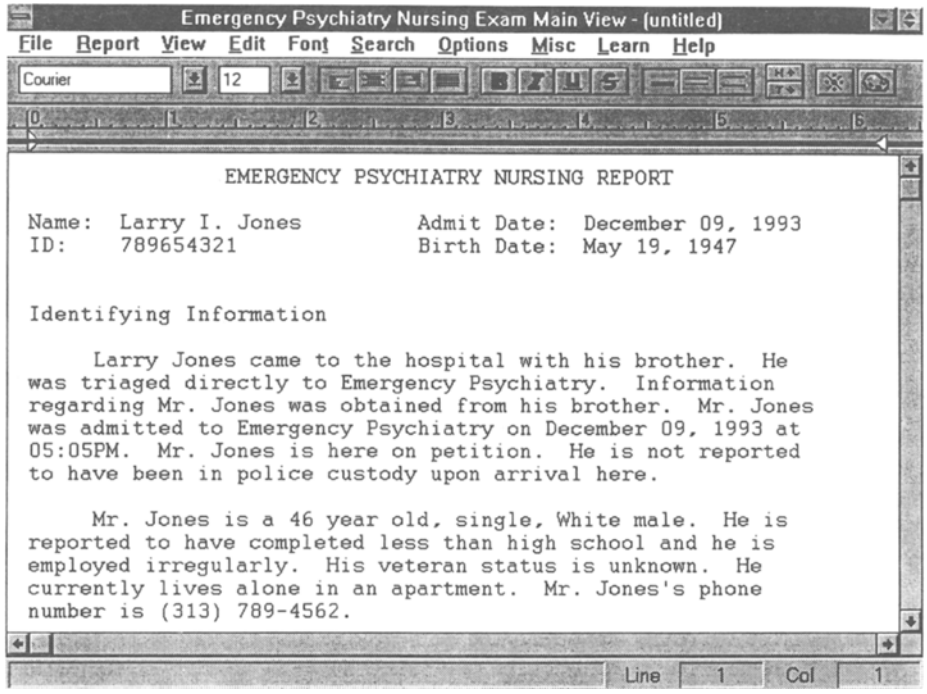

Figure 3. The Main View with a report.

or later and, with the runtime library and help file, a megabyte of available disk space.

Availability

Graduate nurses interested in using EP Nurse should send the senior author a letter stating that they are experienced in interviewing emergency psychiatry patients, that they are licensed at the appropriate level in the state where they will be using the program, that EP Nurse will be used only by or under the supervision of licensed nurses, and that the program will be used only for noncommercial purposes. They should enclose a disk formatted for their system, as well as a stamped, self-addressed disk mailer. The program will be copied onto the disk, which will then be returned in the mailer.

REFERENCES

TANNER, B. A. (1993). Computer-aided reporting of the results of mental retardation evaluations. *Behavior Research Methods, Instruments, & Computers*, **25**, 204-207.

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