Nursing Data, Classification Systems, and Quality Indicators: What Every HIM Professional Needs to Know

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The nursing profession has developed a number of classification systems. What can HIM professionals learn from the processes and results? This article presents an overview of the major nursing classification systems and examines some of the national efforts to standardize nursing data elements.

The impetus for the development of nursing classification systems and other standardized nursing data elements is similar to that of the larger healthcare arena. These factors have been summed up by one expert as: "If you cannot name it, you cannot teach it, research it, practice it, finance it, or put it into public policy."[1] And -- most certainly -- you cannot implement it in a computer-based system.

This article will provide an overview of the major standardized nursing classification systems and related national efforts, with an emphasis on those activities of relevance to HIM professionals. Five nursing systems are reviewed and their status within the context of other broader healthcare classification systems or terminologies is summarized. A program for the evaluation of the extent to which a particular vendor's systems meet the needs for nursing, the Nursing Information and Data Set Evaluation Center (NIDSEC), is described. Finally, the efforts toward the establishment of a National Nursing Data Center are discussed. Implications for HIM professionals are included.

Nursing classifications have been developed to describe the nursing process, to document nursing care, and to facilitate aggregation of data for comparisons at the local, regional, national, and international levels. As opposed to other healthcare classification systems such as ICD-9-CM or CPT, the nursing systems have not been widely used for reimbursement purposes, thus many HIM professionals may be unfamiliar with their contents.

The American Nurses Association (ANA) has played a leadership role in activities related to nursing data sets and classification systems. The ANA established the Steering Committee on Databases to Support Clinical Nursing Practice (SCD) to monitor and support the development and evolution of the use of multiple vocabularies and classification schemes.[2] The SCD aims to propose policy and program initiatives regarding nursing classification schemes, uniform nursing data sets, and the inclusion of nursing data elements in national databases; build national data sets for clinical nursing practice based on elements contained in standards, criteria, and guidelines; and coordinate ANA's initiatives related to all public and private efforts regarding development of databases and the relationships to the development and maintenance of standards of practice, guidelines, and payment reform for nursing services. Providing official recognition of nursing classifications is one of the major strategies for accomplishing these goals. The SCD has recommended that the profession work toward the development of a unified nursing language system that would allow linking or mapping of similar terms retaining the integrity and purpose of each specific scheme/vocabulary and has developed criteria to use to determine whether a candidate nursing classification scheme is ready for official ANA recognition.

Exhibit 1—ANA Criteria for the Recognition of Nursing Classifications

Classifications must:

- be clinically useful for making diagnostic, intervention, and/or outcome decisions
- go beyond an application or synthesis/adaptation of vocabularies/classifications schemes currently recognized by ANA, or present explicit rationale why it should also be recognized

- be stated in clear and unambiguous terms, with terms precisely defined
- have been tested for reliability of the vocabulary terms
- have been validated as useful for clinical purposes
- be accompanied by documentation of a systematic methodology for development
- be accompanied by evidence of process for periodic review and provision for addition, revision, and deletion of terms
- have a taxonomic structure that is conceptually coherent
- have terms that are associated with a unique identifier or code
- leave a machine-readable audit trail
- include defining characteristics, especially for nursing diagnoses

There are five ANA-recognized nursing classifications: the North American Nursing Diagnosis Association Taxonomy (NANDA),[3] the Omaha system,[4] the Home Health Care Classification,[5] the Nursing Intervention Classification (NIC),[6] and the Nursing Outcome Classification (NOC).[7] See Table 1 for a description of each classification. Three additional nursing systems are under review by the SCD. These are the Patient Care Data Set,[8,9] the Nursing Intervention Lexicon and Taxonomy,[10,11] and the Association of Operating Room Nurses Data Set.[12] The SCD has also recognized the Nursing Minimum Data Set[13] for use in clinical nursing information systems and databases.

As previously mentioned, to date the SCD has promoted a unified nursing language rather than recognizing only one system (i.e., a uniform language). For example, note in Table 1 that there are three systems that include nursing diagnoses, three systems that include nursing interventions, and three systems for outcomes. Thus, it is up to the individual organization to select the single system or set of systems that they will implement. All of the ANA-recognized systems have been successfully deployed in both manual and computer-based documentation systems. Factors that organizations take into account in making the selection include the setting for which the system was designed, access (e.g., cost, copyright) issues, ability to represent nursing data at a sufficiently granular level, and ease of implementing, particularly in computer-based systems. Settings and access are summarized in Table 1. Given their complexity, the other two topics warrant further discussion here.

Table 1—Classification Systems Recognized by the American Nurses Association

Classification	Nursing Diagnoses	Nursing Interventions	Nursing Outcomes	Settings	Access
North American Nursing Diagnosis Association (NANDA)	128 nursing diagnoses classified into nine patterns Example: Altered family processes			Across the continuum of care	Copyright North American Nursing Diagnosis Association; written permission required for use
Nursing Interventions Classification (NIC)		433 nursing interventions classified into six domains and 27 classes Example: Bowel incontinence care		Across the continuum of care; e.g., University of Iowa Hospitals, long term care, school nursing	Copyright Mosby-Year Book, Inc.; price negotiated for electronic implementation
Nursing Outcome Classification			193 outcomes classified into six domains and 24	Across the continuum of care	Copyright Mosby-Year Book, Inc.; price

(NOC)			classes; each outcome has a set of indicators scaled 1-5 Example: Caregiver well-being		negotiated for electronic implementation
Omaha System	40 problems classified into four domains with two sets of modifiers Example: Communication with community resources	62 targets with four categories of interventions (health teaching, guidance, and counseling; treatments and procedures; case management; surveillance) Example: Target = Rest/sleep which can be modified by any of the four intervention categories	Five-point Likert scale for three outcomes related to specific diagnoses Example: Caretaking/parenting rated on three scales (knowledge, behavior, and status)	Predominantly community based settings, e.g., Visiting Nurses of Omaha; Penn Nursing Network; Nightingale Tracker	Public domain
Home Health Care Classification	145 diagnoses classified into 20 care components; diagnoses include NANDA plus additional diagnoses developed for the home care environment Example: Knowledge deficit of therapeutic regimen	160 nursing interventions classified into 20 care components with four types of qualifiers (assess, care, teach, manage) Example: Wound care-Teach	Three qualifiers for the nursing diagnoses to predict the outcome (improved, stabilized, deteriorated) Example: Improved acute pain	Predominantly home care settings, but has been demonstrated to have utility for hospital setting	Public domain

As opposed to classification systems such as ICD-9-CM, whose codes are most often assigned post-care through abstraction methods, the nursing classification systems are used directly by the nurse during the course of care. Several investigators have identified that the recognized nursing classification systems, designed to function as enumerative, disjunctive classifications, are insufficient to capture the detail of the clinical encounter and that additional terminologies, which would complement the strengths of the existing systems, are needed to adequately represent a broader range of nursing concepts in computer-based systems.[9, 14-17]

In addition to the granularity of the nursing systems, there are other issues affecting the ease of implementing the nursing classifications in computer-based systems. A recent analysis showed that none of the ANA-recognized systems met the Computer-based Patient Record Institute's (CPRI) features of classification systems that support implementation within a computer-based patient record.[18] The systems are deficient in the following areas, primarily due to the precoordinated nature of the terms in the nursing classifications: clear and nonredundant concept representation, grammar and syntax for combining concepts, and synonymy. The systems are frequently also lacking in administrative cross-references. Complementary to the ANA efforts related to the creation of the Nursing Information and Data Set Evaluation Center described later in this article, the Nursing Informatics Working Group of the American Medical Informatics Association (AMIA) has taken a leadership role in addressing these issues through a series of educational offerings and consensus-building activities in conjunction with the fall symposium and spring congress of AMIA.

Linkages with Other National Efforts

In addition to its recognition activities, the SCD maintains formal or informal relationships with other organizations, including the National Library of Medicine, Health Level 7, CPRI, the American Medical Association, the American National Standards Institute-Health Information Standards Board, the American Society for Testing and Materials, the National Center for Health and Vital Statistics, the SNOMED International Editorial Board, AMIA, and the International Council of Nurses.

Nursing classification systems have also been integrated with other healthcare vocabulary systems. For example, with the exception of NOC, the ANA-recognized systems have been incorporated into the Unified Medical Language System (UMLS),19 and NOC is planned for incorporation in 1998. In addition, NANDA is currently included in SNOMED, and plans are in progress for the integration of additional nursing terms into SNOMED-RT.[20]

Nursing Information and Data Set Evaluation Center

Responding to calls from a variety of groups for standards pertaining to nursing information systems,[21-23] the ANA established the NIDSEC in 1996.[24] NIDSEC develops standards pertaining to automated information systems that support nursing documentation of clinical practice and, for a fee, evaluates vendor products submitted voluntarily by commercial developers. Submissions are reviewed twice a year. Products that adhere to the standards are deemed "ANA recognized." Recognition status is good for three years, after which the developer must reapply.

The standards evaluate the completeness, accuracy, and appropriateness of four dimensions of nursing data sets and the systems that contain them: nomenclature, clinical content associations, clinical data repository, and general system characteristics. Standards for nomenclature assess whether the terms supplied with the system for documenting nursing data come from ANA-recognized vocabularies.[23] Standards for clinical content associations evaluate whether branching pathways are used in navigating among screens, and if so, whether the implicit decision support offered in such pathways is founded on current clinical knowledge. Standards for the clinical data repository (or the database stored as a result of using the system) assess whether nursing data are stored permanently and in a form that enables data retrieval and analysis. General system characteristics standards assess whether the developer includes appropriate information to the potential customer for estimating hardware requirements for processing transactions and storing data permanently. Exhibit 2 contains a sample NIDSEC standard, with its scoring guidelines.

NIDSEC has two goals: to guide developers in the design of products that support nursing documentation, and to provide potential consumers of vendor-supplied nursing systems with a measure of the quality of such systems. The standards are available for purchase from the ANA.[25] Vendors wishing to submit their products for evaluation can contact the ANA to purchase application packets.

Exhibit 2—Sample NIDSEC Standard and Scoring Guideline

N 2
Structured terminology represented in data dictionaries or tables is available to document all phases of the nursing process

Rationale for N 2 to N 2.3
Nursing is a cognitive profession. In order to make clinical decisions, nurses collect data at each step of the nursing process: assessment, diagnosis, setting expected outcomes or goals, planning and executing interventions, and evaluating actual outcomes. It is essential that structured terminology represented in data dictionaries or tables be available for recording all five of the components of the nursing process, or key data elements related to patient care will be missing.

Evidence of Performance
Documentation of the data dictionaries or tables show terms available to nurses for recording assessments, diagnoses, expected outcomes or goals, interventions, and actual outcomes. If the data set is very large, representative portions from each phase of the nursing process can be provided.

Scoring for N 2
How many of the following are represented in data dictionaries or tables: 1) assessments, 2) nursing diagnoses, 3) expected outcomes or goals, 4) interventions, 5) actual outcomes?

Score 1 Four or five
Score 2 Two or three of the five
Score 3 One of the five
Score 5 No data dictionaries or tables are used

The National Nursing Data Center

The establishment of a database for Nursing's Quality Indicators for Acute Care Settings is another significant national effort. The quality indicators were developed as part of ANA's nursing report card to serve as a benchmark for the quality of care given in a healthcare institution (see Exhibit 3 on page 52).[26] This national data repository will provide the profession with a central source of data about nursing practice and its impact on patient outcomes and will provide empirical evidence of nursing's contributions to patient care.

The ANA's experience in its recognition activities and in the creation of the quality report card contributed to the recognition of a need to create the National Nursing Data Center (NNDC).[27] In 1997 the ANA directed the SCD to establish the NNDC as a repository for all quantitative and qualitative data concerning the practice of professional nursing. The NNDC will serve as a resource to meet the information needs related to the nursing profession. Beyond its obvious utility to the ANA and to the broader profession of nursing, the NNDC is created to be an essential resource for policy makers (both elected and staff), the media, other professional disciplines, healthcare providers, third-party payers, and those who receive nursing care -- the patients, their families, and their communities. The benefits of having an active NNDC include health policy development, workplace advocacy, nursing education, quality benchmarking, and research for and about the delivery of nursing care. The first data set to be included in the NNDC will be Nursing's Quality Indicators for Acute Care Settings. More data sets will be added as they are developed.

ANA believes that the NNDC will become a data center that will provide the evidence and analysis needed in order to:

- contribute to the delivery of safe, effective nursing care
- describe nursing practice
- provide quality control data
- facilitate the analysis and evaluation of health policy and advance nursing knowledge
- contribute to the structure of nursing education
- facilitate allocation of nursing resources
- contribute to payment reform for nursing service
- assist in determining the cost of nursing care
- assist in determining nursing's contributions to patient care

Exhibit 3—Nursing's Quality Indicators for Acute Care Settings

1. nosocomial infection rate
2. patient injury rate
3. patient satisfaction with nursing care
4. maintenance of skin integrity
5. patient satisfaction with pain management
6. mix of RNs, LPNs, and UAPs caring for patients
7. total nursing care hours provided per patient day
8. patient satisfaction with educational information
9. patient satisfaction with care
10. nurse satisfaction with work environment
11. additional critical data elements to be determined

Implications for HIM Professionals

Nursing is an information-intensive profession, and nurses are experts in the diagnosis and treatment of human responses to illness, prevention of illness, and health promotion. But typically, they are not experts in information management other than for the purposes of diagnostic and treatment decision making. Most practicing nurses are not aware that classification systems exist (except for NANDA) for nursing, nor are they aware of the multiple benefits of such systems. Thus, HIM professionals, as experts in information management, have a collaborative role to play in working with nurses in areas such as computer-based patient record system selection and multidisciplinary documentation (e.g., critical paths, care maps). For instance, the HIM professional is well equipped to address issues related to data reliability and validity as well as educating the healthcare delivery team in other issues related to the potential for multiple uses of the data collected in the course of care delivery. In some institutions, the HIM professional may also function within the healthcare team as the expert on vocabulary issues related to computer-based patient record systems by sharing information about national efforts and related issues with other team members. The HIM professional also

has the potential to act as a consultant to quality management teams in designing reliable and valid strategies to prospectively or retrospectively collect chart data.

The provision of healthcare is a multidisciplinary effort. In this era of numerous requests for data and information from multiple accrediting, governing, and quality monitoring agencies, it is vital that the HIM professional be aware of classification systems and related national efforts, beyond those that are typically physician-centric in nature (e.g., ICD-9-CM and CPT). Without reliable and valid data concerning the contributions of the entire healthcare team, it is truly impossible to engage in the practice of evidence-based healthcare delivery.

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Notes

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DSM-IV Gets a Fresh Look

Due to changes initiated by research, mental health continues to be a fluid area of healthcare. New research leads to better-informed physicians and, over time, increased social awareness of the conditions caused by mental illness. But keeping pace with these changes is not easy. It requires open minds and forward thinking -- and a lot of hard work. Which is what the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) task force is currently facing as it undertakes the publication of an updated edition of the manual.

A New Era Begins in Healthcare

According to Harold Pincus, MD, deputy medical director of the American Psychiatric Association (APA) and vice chair of the task force on DSM-IV, the road to DSM-IV began in the 19th century, when mental health information first was officially collected in the 1840 US census. However, it was not until 1952 that DSM-I was published. The manual was a variant of ICD-6 -- the first version of ICD to contain diagnoses for mental disorders -- to assist physicians in diagnosing patients with mental disorders. As the first official manual of mental disorders that focused on clinical utility, DSM-I contained a glossary of descriptions of the diagnostic categories.[1] As ICD was revised over the years, so was DSM, eventually leading up to the publication of DSM-IV in 1994.

Today, DSM-IV, published by the APA, is undergoing its first stages of a text update. Its scheduled release is 1999. Michael First, MD, a physician at Columbia University¹s Department of Psychiatry and co-chair of the DSM-IV task force, says the task force is currently reviewing DSM-IV's text. According to First, the updated version of the manual will not contain any changes in classifications or criteria. Pincus says that ICD-10-CM codes will be included as additional material only when they become officially implemented -- most likely as an appendix.

Though the task force to update DSM-IV did take the prospective emergence of ICD-10-CM into consideration for the update, the principal reason for the new version is this: In its role as a textbook, information in the manual needs to be updated, says Pincus. As with any textbook, the material becomes dated due to new studies and changing social trends. This change "reflects the fact that the DSM-IV has become a prevalently used medical textbook," he adds. Updates and revisions of DSM take place periodically.

A Different Viewpoint

From an HIM professional's perspective, the update has a few small but significant implications. Since no one knows when ICD-10-CM will be implemented, the issue of creating a functional crosswalk between the updated DSM-IV and ICD-9-CM -- already a detailed task -- is made increasingly complex when taking ICD-10-CM into consideration.

According to Andrea Albaum-Feinstein, MBA, RRA, a private consultant who is currently revising her manual, *DSM-IV Crosswalk: Guidelines for Coding Mental Health Information,* the differences in clinical classification between the ICD-9-CM and DSM-IV make developing a crosswalk and writing coding commentary a challenging task. Unfortunately, the most appropriate clinical category from the tabular list from the DSM-IV diagnosis does not always correspond to the classification assignment referenced from the alphabetic listing for the DSM-IV or synonymous terms. Although the DSM-IV codes correspond to categories or subcategories in ICD-9 categorical listings, code assignment differences arise when using the ICD-9 alphabetic index to code DSM-IV or synonymous terms. This is because the ICD-9-CM classification system was based on mental health terms and ideas from 20 years ago. Albaum-Feinstein has informed First of these coding assignment differences. As a result, the APA has approached the National Center for Health Statistics to resolve as many of these indexing and classification differences as possible.

Albaum-Feinstein emphasizes that despite the challenges of working with multiple classification systems, a solid knowledge of them can help any HIM professional. She says that learning about the clinical side of DSM can improve understanding of and ability to explain the classification of the DSM-IV system and better code the equivalent ICD-9-CM corresponding diagnoses.

Where to Turn for Additional Help

- Another mental health resource to be aware of is the DSM-IV-PC, or primary care edition. "The idea behind the primary care version is that there are a tremendous amount of mental diagnoses to recognize in primary care," says First. To translate DSM-IV into a useful resource for primary care physicians, the task force reconvened after the publication of DSM-IV to modify the original manual. The result was an abbreviated manual focusing on mental disorders that primary care physicians commonly detect in patients. DSM-IV-PC is "presented in a way to make it easier for primary care physicians to practice," says First.

- Also forthcoming is the APA's tentatively titled *Handbook of Psychiatric Measures and Outcomes.* Currently in draft form, it will cover a range of assessment domains including symptoms, function, and outcomes. It also will evaluate psychiatric measures by their components, reliability, validity, strengths, weaknesses, and clinical utility. The main purpose of the handbook is to provide clinicians working in mental health and primary care settings with some available rating scales and tests that may be useful in clinical care of patients or for interpreting treatment.

-- J.B.

Note

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