Application of the Omaha System for Persons with Psychiatric/Mental Health Problems.
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Purpose:
This module provides an opportunity for you to successfully apply the Omaha System for persons who may be experiencing psychiatric/mental health problems. In addition, you will have an increased awareness of the use of the Omaha System with the School of Nursing Nurse Managed Centers.

Learning Outcomes:
After completing this module you will be able to:

- Identify appropriate Omaha System problems during an assessment of a person with psychiatric/mental health problems.
- Select the appropriate interventions and targets for the identified problems.
- Correctly rate the outcomes of the problem in the areas of Knowledge (K), Behavior (B), and Status (S).
- Develop a care plan for future care.
- Discuss the use of the Omaha data collection within the Nurse Managed Centers.
- Recognize the relationship between the use of the Omaha System and providing quality care.
- Identify the protocol for data collection of the Omaha in the Nurse Managed Centers.
- Document services provided on a Standardized Omaha System Documentation tool.
- Collect pre and post Omaha Data on top 3 priority problems for assigned clients on a scantron form.
- Discuss the value of the Omaha System for providing collaborative care.

Required learning activities:

1. Purchase a copy of the Omaha Module in the Associated Students Print shop and complete the module.
2. Read the case study for a person in the community with psychiatric symptoms.
3. Based on the case study provided identify the two top priority problems, include the Domain.
4. Rate the problems in the K, B, S for each of the two problems.
5. Identify the Interventions and Targets for each problem.
6. Develop a Care Plan for follow-up for the person in the case study.

Read,

"Mini-Lecture":

The Omaha System is a standardized, reliable and valid method for documenting and managing patient care. Reliability and validity of the Omaha System has been established with extensive testing (Martin, 2005; Martin & Scheet, 1992a; Martin,

Scheet, & Stegman, 1993). You will find more details about the System at the Omaha System Website found at www.OmahaSystem.org .

The System includes a rating scale for measuring outcomes (Martin & Martin, 1997; Elfrink & Martin, 1996) based on the client's knowledge (what the client knows); behavior (what the client does) and status (the client's physiological or psychological well-being) see the Omaha System site for the rating scales found at: http://www.omahasystem.org/problemratingscaleforoutcomes.html .

There are 43 problems in the Omaha System organized within four domains—Environmental, Psychosocial, Physiological, and Health Related Behaviors see (http://www.omahasystem.org/problemclassificationscheme.html). Modifiers and signs and symptoms follow the domains and problems. The Omaha System includes a rating scale for outcomes on three subscales: Knowledge (K), the ability of the client to remember and interpret information; Behavior (B), the observable responses, actions, or activities of the client fitting the occasion or purpose; and Status (S), the condition of the client in relation to objective and subjective defining characteristics. The rating scale (Likert-type) scoring ranges from 1 to 5 points, where a rating of 1 indicates no knowledge, behavior that is not appropriate, and extreme signs and symptoms, and a rating of 5 indicates superior knowledge, consistently appropriate behavior, and no signs and symptoms.

The intervention scheme can be found at http://www.omahasystem.org/interventionscheme.html and reflects nursing actions or activities in four hierarchical levels: Health Teaching, Guidance, and Counseling; Treatments and Procedures; Case Management; and Surveillance (Martin, Leak, and

Aden, 1992, page 48). Targets (62) are defined as objects of nursing intervention activities. Lastly, the system includes client-specific information that may be needed for detailed information in the client's plan. A pocket guide is available for users of the Omaha System and operational definitions are included, as well as potential interventions and targets (Martin & Sheet, 1992b) and the revised System is available in Martin (2005). Go to this URL to see the documentation of the Omaha System in Nightingale Notes http://www.champsoftware.com/products/Nightingale%20Notes%20August%20Release_demo_fs.htm .

The System has been used extensively and researched in a variety of settings. For example, the Omaha System is being evaluated as a tool to link standardize languages from acute care settings to home care (Bowles, 1999). The System is also being integrated into home care agencies with a required computerized documentation system, Outcome and Assessment Information Set (OASIS) (Westra & Solomon, 1999).

Using the Omaha System for Community-Based Mental Health Nursing.

Little data are available that describe the Omaha System's use in community-based mental health settings. However, persons with psychiatric disorders living in the community do have many health care problems (Chisholm et al., 2006; Chwastiak et al., 2006) which was confirmed in several studies conducted in the Nurse Managed Centers in the School of Nursing at San Jose State University (Barrera, Machanga, Connolly, & Yoder, 2003; Connolly & Elfrink, 2002; Connolly & Novak, 2000; Connolly, Huynh, & Gorney-Moreno, 1999; Connolly, Mao, Yoder & Canham, 2006). The findings suggested that clients had multiple physical and mental health problems requiring primary health care, supporting the importance for redesigning a primary health care system for this

vulnerable population (Chisholm et al. 1997). Another related implication is the need for sustaining social support and long - term rehabilitation for persons with brain disorders (USDHHS, 1999; Palmer-Erbs, & Anthony, 1995).

One continuous barrier for efficient and effective referrals and care is the lack of coordination and access to client information. In fact, a major barrier to effective care is the current funding approach that separates mental health care funds from medical care. For example, reimbursement guidelines for the County pharmacy limit prescriptions for mental health clients to psychotropic medications only. Therefore, the client must see another physician, increasing costs. This situation challenges the client to manage his/her own health care in a complex system. Since these clients are already at a disadvantage due to a psychiatric/mental health problem, this may also decrease the probability of follow up regarding their physical condition.

The collaboration facilitated in the project in which we used the Nightingale Trackers (NT) actually enhanced and altered referrals increasing the quality of care for the clients, who were at risk for costly health care problems (Connolly & Elfrink, 2002). The following is an example of an actual case described in Connolly & Elfrink, 2002, which illustrates the importance of using information to improve referrals to preserve the quality of client care. (Some identifying information has been changed for protection of client anonymity).

> *Juan Rivera was living in a boarding house and already receiving mental health care had just been diagnosed with Diabetes. There was concern that impaired cognitive processes as a result of his psychiatric diagnosis (schizophrenia) might interfere with retaining all the information and instructions that he was given to*

> *perform his own testing for glucose, keeping a journal of the results, and reporting back to the physician. The student had already been working with the client, thus the baseline data were already entered into the NT system. The health coordinator e-mailed the faculty member requesting that when the student visited the client that she work with him to, reinforce the teaching not only for testing his glucose but also for dietary changes. The student faxed the results of the glucose testing to the physician's office; the client avoided a trip to the physician's office as well as the cost of an office visit. The student was also able to review the protocol for diabetic teaching on the NT Web Browser. At the end of the clinical experience, the student e-mailed the results of her visit to the faculty member for review. The faculty member reviewed the documentation and sent the student a relevant patient education web site that she could view and bring the information to the client during the next visit. The student's plan included taking the resident to the University library to show him how to access the health education web site for himself (pages 353).*

This case study illustrates how extremely important it is to have the ability to communicate referral information with the targeted at-risk population, persons with psychiatric disabilities. Because of the therapeutic relationship with the student and the nurse from the agency, the client was much more likely to allow an assessment and that information could be conveyed to the appropriate health care provider enhancing the appropriate interventions in a timely manner.

Utilizing the Omaha Nursing Documentation System for Areas of Collaboration.

The Omaha Nursing Documentation System (Omaha System)(Martin, 2005; Martin & Scheet, 1992a) is a model for clinical practice, documentation, and data management. The Omaha System is adaptable for multidisciplinary use. It was an integral part of the Transdisciplinary Project since 1994 (Connolly & Novak, 2000). The Omaha System data collection tool has been adapted by the School of Nursing's Nurse Managed Centers into a scantronable form which is entered for summary and demographic analysis of all client data from the NMCs. Nursing students are taught the Omaha System through a Nursing Process course with a module, video and mini lecture prior to participating in the Project. Students also have some experience in applying the system in other NMCs.

During the Spring 1997 semester, speech pathology students also used the Omaha System. This was the first time that the Omaha System of documentation was used by a discipline other than nursing. The speech pathology students were oriented to the Omaha System through a module, video, and group training session. Additional training was provided at the clinical to students of both disciplines on using the scantron forms for data collection, the complete data base, health history, care plan, and individual weekly record. Data were collected weekly and turned into the Nurse Managed Centers. Data were processed and analyzed at the university through the Nurse Managed Centers projects. An example of the outcome rating results of the collaboration for the care of one resident during the Spring 1997 semester, CCF# 9012, for the Problem of Personal Hygiene, showed progress from an initial Knowledge rating of 2 to a final rating of 4, an initial Behavior rating of 2 to a final rating of 4, and an initial Status rating of 3 to a final rating of 4 (Connolly & Novak, 2000).

Researching the Effectiveness of Care.

Faculty and students practicing at the Nurse Managed Centers have continued to collect data over time. Faculty have reviewed and analyzed the data for trends and from one set of data collected during the fall 2001 semester for 47 clients with mental illness a statistical improvement in the outcome ratings based on the nursing interventions was noted (Barrera, Machanga, Connolly, & Yoder, 2003). These results were based on the results of pre and post test analysis of the ratings for K, B, & S for all problems identified. In a more recent study data were collected from fall 2002 through fall 2004. And, for 85 unduplicated clients with mental illness and for the problems of Emotional Stability (mental health), Interpersonal Relationship, and Social Contact, there was a statistical significant improvement in the ratings for K and improvement for B, and S. However, for the problems of Nutrition, Prescribed Medication Regimen, and Personal Hygiene there was statistical improvement in K, B, & S. Clearly, the nursing care made a difference for these clients.

It is important as we continue to provide services for our clients in the Nurse Managed Centers that we document, review and analyze our practice as one method to ensure quality care (Canham et al. 2008). There are specific protocols to be used which are part of this module and will help you understand how and when to collect data for the research component of our nursing practice, helping to build our evidence based teaching and practice (see Research Project). You will be documenting your interventions and the client ratings each time you see your client (see Problem List/Ratings Worksheet/Interventions).

Now that you have worked through this Application module as well as the Omaha Module, you are ready to read the Case Study, Identify and document the Problems and

rate each problem then complete the Care Plan in this module. You will need the Omaha System 2nd Ed. (2005) in order to complete the work.

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CASE STUDY:

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INFORMATION OBTAINED DURING A VISIT/ENCOUNTER:

The psychiatric home care nurse is visiting a 62 year old female, African American. She was diagnosed with Schizophrenia, chronic undifferentiated; and is also receiving care for a chronic respiratory disease and cardiovascular disease. She has been living in a licensed board and care facility for the past two years in an urban area. The Administrator is concerned because the resident has been given a warning and faces a possible eviction because of her decreasing personal hygiene. He tells the nurse that he is concerned that her psychiatric medications are not controlling her symptoms. The nurse is taken to the resident's room and the resident agrees to talk to the nurse. The resident's clothes are wrinkled, and soiled with food, her hair is matted, finger nails long and dirty and the room is cluttered with piles of dirty clothing, plastic bags, and broken pocket books. The resident is looking through her bags as if she was searching for something. She moved about the room frequently, picking things up then looking distracted and moving to the next item. She frequently stopped and argued with herself. Her mood shifted rapidly during the visit. The resident asks the nurse "Are you my new conservator? You look like one…they are all after my money, and they try to keep me from my family…as soon as my boyfriend gets a new job, we are going to get out of this place. They want to throw me out anyway." The nurse explains who she is and asks permission to talk with the resident. The nurse notices pictures on a cluttered dresser and asks the resident about the people, the resident stops and tells her they are her grandchildren, that they don't live near by so she doesn't get to see them very often, sometimes she got to play with them and she really misses them. The nurse asks if she knows why she has come to see her. The resident says no but since she has not been able to take a shower because people are always in the bathroom that she suspects that the other residents are complaining about her. "You know it's one of the rules and they said they could even throw me out,...but it's not my fault." The nurse validates her understanding that her personal hygiene does seem to have become a problem and is there any way she the nurse might help her with that problem. The resident says that she tries to take a shower but she has a hard time concentrating on getting everything together for the shower and that sometimes the voices start shouting at her when she is in the shower. "I'm not sure when I showered last." She also reported that a new resident keeps banging on the bathroom door and demanding that she get out. The nurse asks if the resident would be willing to take a shower with the help of the mental health worker who could help her assemble what she needed and keep the other resident from interrupting her during the shower. She agreed she would try. The nurse asks if the resident could use some help with her laundry. The resident responds that if she could just remember what she needed to do each time and where she left the soap and which clothes should be washed together that she could probably do that herself. During the visit the resident began to cry and said, "I used to have a beautiful little apartment and everything was clean and very neat—before I got

sick, my grandchildren could visit me then." The nurse asks the resident if she knows what types of medications she is taking and if she thinks they are working for her. The resident is able to name each of her medications and adds that sometimes the doctor has to change them; … "they keep telling me not to drink so much coffee and coke and to stop smoking…something about the medications…" The nurse asks if she has ever tried decaffeinated coffee and cokes, the resident says "no." The nurse asks if she could come back and visit again in a few days and if it would be all right to talk with the Administrator to get some help for her with her shower, and her laundry, and to see if decaffeinated coffee and coke are available, as well as making an appointment to have her medications evaluated—the resident agrees.

Check your answers with the Case Study, Emma found at the site listed below:

http://www.omahasystem.org/emmab.html

SAN JOSE STATE UNIVERSITY.
SCHOOL OF NURSING.
NURSE MANAGED CENTERS.
OMAHA SYSTEM.

All of the Nurse Managed Centers (NMCs) use the OMAHA System to document patient care and care outcomes. In an effort to increase consistency of data collection, the NMC Research team has provided guidelines to assist the nursing students in the process.

DATA COLLECTION PROCEDURES:

Clients are identified by assigned numbers (these are provided by the faculty at your agency).

Client Contact Forms (CCFs = Blue) are completed at each visit and submitted to the designated person in your agency. These provide demographic data and number and type of contacts, provider, and amount of time spent in providing care.

Client Data Forms (CDFs = Pink/Red) are completed at the ***first*** visit of the semester and at the ***last*** visit of the semester. **DO NOT USE THE CLIENT'S NAME OR YOUR NAME ON THE FORM—INITIALS ONLY.**

FIRST VISIT: Select and prioritize the ***3 MOST PREVALENT PROBLEMS***. Complete the Problem, Category, and Target (intervention) areas of the form. Indicate the Knowledge (K), Behavior (B), and Status (S) rankings. We are collecting data regarding the 3 most prevalent problems only. If additional problems are identified at the first visit or subsequent visits, those will be charted in the client chart but a CDF will not be completed. Maintain the Initial Client Data Form or a copy in the client chart for reference at the end of the semester.

FINAL VISIT (usually end of semester): Complete a second Client Data Form (Pink/red). Address **the same 3 PROBLEMS IN THE SAME PRIORITIZED ORDER** as indicated on the initial CDF and determine the K, B, S indicators. Even if new problems have been identified during the semester, complete the CDF for the 3 original problems identified.

TIMELINE FOR DATA COLLECTION:

- Weeks 1 to 5: Collect Pre-test data.
- Weeks 13 to 14: Collect Post-test data.
- Clients admitted to service after week 5 will not be included in the data collection for *THE SEMESTER*. There must be a minimum of 6 weeks between the initial visit and the final visit.
- Submit the initial *CDF ONECE IT IS COMPLETED AND THE FINAL CDFs at the end of the semester*.

If at anytime you have questions regarding completing the CCF or CDF, please consult with your assigned faculty person. The faculty at the agency or Dr. Daryl Canham (email address is darycan@aol.com .) can answer questions regarding data collection procedures.

Thank you for your participation and assistance in our efforts to document client outcomes and monitor quality of care.

SCHOOL OF NURSING, NURSE MANAGED CENTERS.
NURSING CARE PLAN.
OMAHA SYSTEM .

PATIENT/CLIENT NAME:

CCF NUMBER:

Nursing Diagnosis:

Medical Diagnosis:

Problem No.	Problem Title.	Intervention Category.	Target (s).	Date of Plan.	Specific nursing actions.	Date Problem Dc'd.

Problem No.	Problem Title.	Intervention Category.	Target (s).	Date of Plan.	Specific nursing actions.	Date Problem Dc'd.

Nurse's name and signature:

	beginning of the care you provided and the ratings at the end of care.		
Overall Score	**Level 3**	**Level 2**	**Level 1**

SCHOOL OF NURSING, NURSE MANAGED CENTERS
NURSING CARE PLAN
OMAHA SYSTEM

PATIENT/CLIENT NAME: Case Study
CCF NUMBER: 00256
Nursing Diagnosis: Altered thought processes

Brief description and assessment of patient/client: DSM-IV 295.90, GAF 30; 62 year old female African-American living in licensed board 7care facility. Additional medical problems chronic respiratory disease and cardiovascular disease. Possible eviction related to inadequate personal hygiene. Demonstrates hallucinations, delusions, and mood shifts. Problems with high intake of caffeine and nicotine.

Problem No.	Problem Title	Intervention Category	Target (s)	Date of Plan	Specific nursing actions	Date Problem Dc'd
12	Mental Health	I. Teaching, guidance, & counseling	28 Interaction	2/28/06	Establish therapeutic relationship visit 3/1 to reassess for weekly visits	
			67 dietary Management	2/28/06	Assess Caffeine intake next visit; initiate gradual decrease	
		III. Case Management	12 Day Care respite	2/28/06	Consult with Administrator of B&C each visit Follow up results of appointment with primary care physician and medication evaluation	

Problem No.	Problem Title	Intervention Category	Target (s)	Date of Plan	Specific nursing actions	Date Problem Dc'd
		IV Surveillance	49 Signs and symptoms mental & emotional	2/28/06	Assess mood shifts, hallucinations, delusions, suicidal and homicidal ideation	
38	Personal Care	III Case Management	41 personal hygiene	2/28/06	Assess effectiveness with use of mental health worker each visit	
28	Respiration	IV Surveillance	50 Signs and symptoms physical	3/7/06	Complete physical assessment	
29	Circulations	IV Surveillance	50 Signs & Symptoms	3/7/06	Complete physical assessment	

Nurse's name:

Rubrics Areas

Rubrics

Edit Rubric

Nursing Care Plan

Rubric List • Edit Rubric

Rubric Statistics

Preview Rubric

Properties | **Levels and Criteria**

Add Criterion | Add Level | Add Criteria Group | Reorder Criteria

Criteria	Level 1	Level 2
Criterion 1, Utilizes appropriate format	Plan contains the following: 1. The template for the care plan is used 2. Client's name 3. CCF number 4. Nursing diagnosis which is relevant to the client and his/her problems 5. A brief description and assessment of client with DSM-IV diagnosis is listed	The care plan contains: 1. Omaha System problems which reflect client's problems relevant to his/her DSM-IV diagnosis and nursing diagnosis

Criterion 2, Applies Omaha System	1. Approriate Intervention categories are listed 2. Appropriate Targets are listed 3. Date of Plan is listed 4. Specific nursing actions are listed and related to interventions and categories 5. Interventions and nursing actions are realistic	1. Specific nursing actions reflect evidence based nursing approaches to quality care. 2. Weekly documentation of care are recorded either on the weekly Omaha System Documentation forms or Nightingale Notes web-based system.
Criterion 3, Applies neurobiological knowledge to care practices	Nursing interventions and targets reflect knowledge of neurobiological theories of etiology of common psychiatric health disorders.	Nursing interventions reflect knowledge of neuroanatomical and neurophysiological basis of and relationship to observable patient behaviors and symptoms of psychiatric disorders.
Criterion 4, Patient teaching	Specific patient teaching strategies are listed.	Teaching strategies reflect knowledge of theories of teaching and health literacy which are congruent with the client's developmental and cognitive functioning.
Criterion 5, Documents weekly with Outcome Rating Scale K,B.S	Omaha System problems are identified Problems are relevant for client and his/her diagnosis Weekly documentation form(s) are initiated or Nighitngale Notes are initiated and include ratings for Knowledge, Behavior and Status.	Provides documentation of care provided weekly utilizing Omaha System Form with outcome ratings for Knowledge, Behavior and Status for each problem for which care was provided. Ratings reflect accurate assessment and evidence that the Martin (2005) definitions for ratings was used.
Criterion 6, Develops Summative Evaluation Report	Write a summative evaluation of the client's progress based on the care plan and Omaha System. Describe the number of times you saw the client; the Omaha Ratings for Knowledge, Behavior, and Status (KBS) for the identified problems that were identified in the	Recommendations for the client for further care include whether or not the client would like to work with a student again in the future.