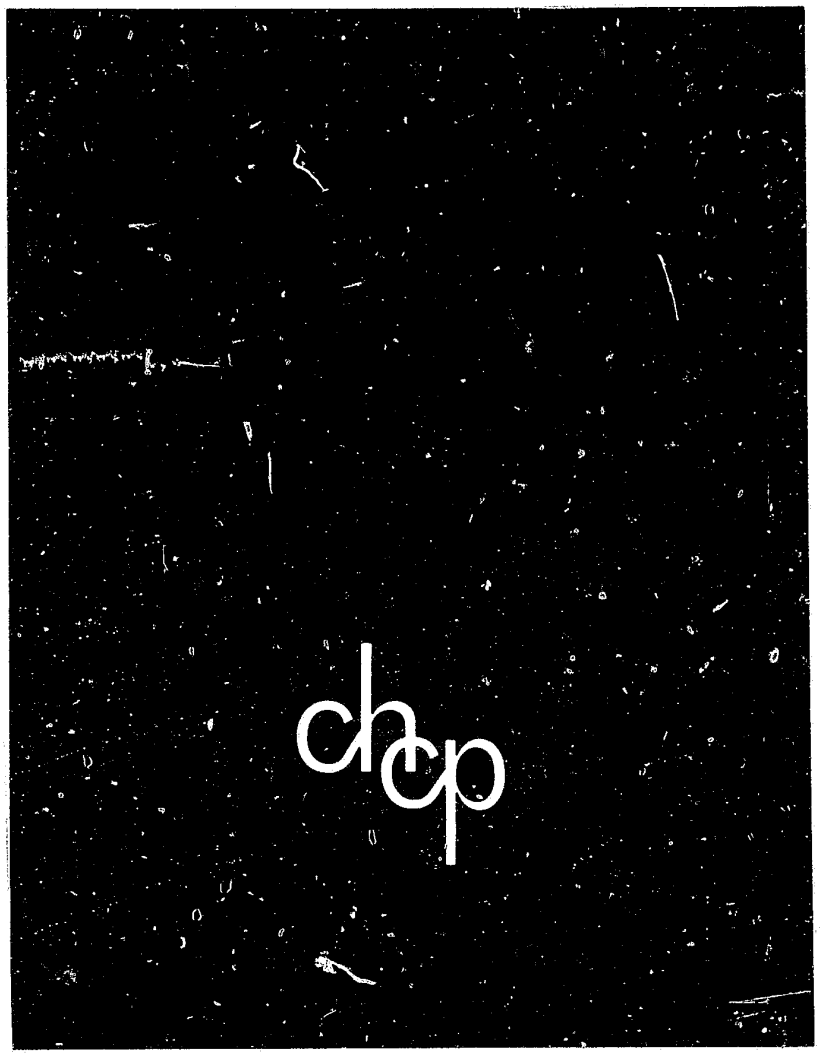

CORRECTIONAL HEALTH CARE PROGRAM

Correctional Health Care Program

RESOURCE MANUAL

PROBLEM ORIENTED MEDICAL RECORDS
IN CORRECTIONAL HEALTH CARE

MICHIGAN DEPARTMENT OF CORRECTIONS
OFFICE OF HEALTH CARE

LAW ENFORCEMENT ASSISTANCE ADMINISTRATION
UNITED STATES DEPARTMENT OF JUSTICE

Correctional Health Care Program
Michigan Department of Corrections
Office of Health Care

PROBLEM ORIENTED MEDICAL RECORDS
AND
CORRECTIONAL HEALTH CARE

Prepared by:

Susan Helbig, R.R.A.
Seattle University

and

Jack A. N. Ellis, M.S.W.
University of Washington

for

Department of Community Health Science
Colleges of Human and Osteopathic Medicine
Michigan State University

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Michigan Department of Corrections
Office of Health Care
3222 South Logan - Logan Center
Lansing, Michigan 48913

A C K N O W L E D G E M E N T S

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C H C P P R O J E C T S T A F F

Michigan Department of Corrections
Office of Health Care

Michigan State University
Colleges of Human and Osteopathic Medicine
Department of Community Health Science

University of Michigan
School of Public Health
Department of Medical Care Organization

American Medical Association
Division of Medical Practice
Program to Improve Health Care in Correctional Institutions

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Problem Oriented Medical Records in Correctional Health Care

Quality Assurance: A Brief Overview for the Correctional Health Care Administrator

Resident Guide to Self-Care

Sample Policy Manual for Correctional Health Care

F O R E W O R D

The issues of adequacy, accessibility, and quality of health care service delivery in correctional institutions are increasingly receiving well-merited attention. Long plagued by neglect and paucity of resources, most correctional agencies throughout the country have recognized the need for clear direction in addressing these issues. The unique characteristics of prison populations and facilities pose a problem in applying directly the standards and policies which prevail in community health care settings. Once the basic ingredients common to good health care practice have been identified, the challenge remains of their adaptation without essential compromise to the correctional environment. Implementation of a system which meets statutory and professional standards is the responsibility of correctional health care administrators in the 1980's.

Through a grant from the Law Enforcement Assistance Administration, the Michigan Department of Corrections has provided technical assistance to ten states with a view to improving their health care system for residents of correctional institutions. This manual is one of a series published under auspices of the grant. Together, the manuals will support and extend the training sessions and technical assistance efforts of the past two years. Their purpose is to define concisely the major elements which must constitute a comprehensive health care program for a correctional agency.

There is no substitute for proper planning, adequate resources and good management. These manuals can assist in the planning effort to identify the kind of resources which will comprise an adequate program. In addition, they address the alternatives which must be considered, the integration of various components, and establish a foundation for the decisions which must be made by each agency.

The manuals have been compiled by persons who are experts in their professional field and by persons active in the delivery of health services to correctional residents. There are too many divergencies among correctional agencies to permit a single approach to be universally applicable. For this reason, the manuals are intentionally broad in scope and will require careful analysis and specification by each user.

A health care system does not stand alone and isolated from its environment. It can succeed only through a cooperative and carefully planned effort which involves health care personnel, staff of the correctional system, community health resources, and residents as interested consumers of the services. Where multiple institutions exist within a state correctional agency, appropriate central direction and coordination are essential for coherent and consistent form and quality of the services provided. It is at this level, in particular, that the overall planning, resource development, and management of policy should occur.

These manuals are written in a simple "how-to" format and are intended to be self-explanatory. Local regulatory agencies and other community and professional health resources can be helpful in their interpretation and application.

The goal which has prompted development and issuance of this manual and of others in the series has been attainment of professional quality health care for residents of correctional institutions comparable to that available in the community. The sponsors will consider their efforts well rewarded if, as a result, changes are implemented which improve access and cost-efficient delivery of needed health services.

Jay K. Harness, M.D.
Director
Correctional Health Care Program

P R E F A C E

This resource manual represents one of a series of manuals resulting from the planning and implementation of an intensive workshop and technical assistance program conducted at Michigan State University. These and other educational and professional development materials have been produced to assist correctional health care providers in developing and implementing more effective programs for the populations they serve. The manual has been designed as a practical guide for program development based on current state of the art, advice from prominent experts in the field, and information drawn from direct experience with health care providers in the Correctional Health Care Program Project. As such, the concepts, methods, and practices presented will contribute to the need for advanced knowledge in this highly specialized area of health care delivery.

Through the Department of Community Health Science, the Colleges of Human Medicine and Osteopathic Medicine at Michigan State University have been privileged to work with the Michigan Department of Corrections' Office of Health Care and the Law Enforcement Assistance Administration as part of the Correctional Health Care Program. Participation in this challenging and worthwhile endeavor has allowed us to further our commitment to improved health care services and to extend knowledge and experience in this recognized area of need.

Joseph Papsidero, M.P.H., Ph.D.
Director
Correctional Health Care Project
Michigan State University

Thomas Gunnings, Ph.D.
Director
Correctional Health Care Project
Michigan State University

C O N T E N T S

CHAPTER 1

AN OVERVIEW OF THE PLACE OF MEDICAL RECORDS IN PRISON HEALTH CARE

I. Background. Health care in prisons, particularly quality health care as a right extending to all prisoners, is a relatively new concept in correctional policy. Prisons themselves are a fairly new invention, dating back only to 1820 in North America, and conceived as a more humanitarian way of dealing with offenders than capital punishment or maiming or disfiguring them. The early prisons, however, were designed to "separate the offender from all contact with corruption" and focused most of their organizational and operational emphasis on isolation as the means of reformation, with little thought being given to prison mental or physical well being. Indeed, as the concept of isolation (including silence) took hold, prisons became extremely violent places in which prisoners were physically and mentally brutalized in order to enforce the obedience to the rules that were presumed to enhance rehabilitation.

It was an easy jump from the idea of penance through isolation and silence to the idea that prisoners ought to be taught good work habits. Thus was born the notion of prisoners as laborers. This may have at least set the state for concern about prison health care, but it was purely an economic concern, since sick prisoners were less productive than healthy ones.

Prison health care was introduced as a social control mechanism, and could be evaluated on a cost-benefit basis. That is, if the health care providers could keep the prisoners healthy then productivity would be higher.

Unfortunately there were never enough jobs around to really test this formula out, so prison health care was relegated to a maintenance role in the system, and given very low priority in terms of resource allocation or administrative interest.

II. Recent Developments. By the 1960s, however, an increased awareness of the importance of prison health care came about, partly as a result of the efforts of a few highly committed people and organizations,[1] but also as a result of the "civil rights revolution" of the 60s that brought a number of political prisoners into reformatories and penitentiaries throughout the nation. These prisoners and their attorneys began filing legal briefs and forcing prison administrators to recognize prisoner rights to adequate medical, dental, and mental health care.

The dilemma for prison administrators was that the health care programs they did offer did not measure up to any standards set in the community at large, nor were there adequate standards within the criminal justice system itself that might serve as guides to good practice.

As the public became aware of the abuses and neglect in this area, prison officials found themselves facing serious challenges from citizen action groups and the press about the levels of service being offered. The end result has been an increased concern on the part of prison officials with the delivery of health services in prisons, and with the quality of health care provided. Parallel to this has been a proliferation of statements of standards for prison health care from a wide range of criminal justice interest groups such as the American Corrections Association, the Law Enforcement Assistance Administration, the American Medical Association, the American Public Health Association, etc.

All of those groups have stressed the importance of good health care records as the underpinning foundation of quality health care in prisons. Good records reflect good management, and should reflect a professional and disciplined approach to health care service delivery.

III. The Purpose of Medical Records. In the United States today, there are roughly one-quarter of a million adults housed in state and federal prisons. Prisons in our society offer a pre-paid type of health care which means there are the beginnings (in one form or another) of at

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[1] National Council on Crime and Delinquency, John Howard Society, Salvation Army, etc.

least one quarter million medical records.[2] Thus, the task of the medical record practitioner in prison health care begins to loom large. This task is further complicated because of the variety of types of records kept, and the various practices employed in handling and managing records in prisons. For example, in some prisons the medical record stays in the prison even if the prisoner is moved to another prison. Likewise, some prisons keep all medical records on a given prisoner in one folder, others may keep several separate medical records on the same prisoners.

Differences from the outside medical community also appear in the kinds of data that are gathered on prisoners, the way the data are arrayed in the charts, and in the basic format of the record. The two most common forms of record keeping are known as "source oriented" or "problem oriented" records.

Many standard setting agencies and organizations consider the problem oriented record to be the most suitable for prison health care for the following reasons:

1. The problem oriented medical record displays a patient's treatment in a clear, logical format;
2. The POMR is a dynamic communication tool for the entire health team;[3]
3. The abstracting of data for auditing the quality of care given, and the utilization of services is easier for non-clinical personnel;
4. The POMR record serves as an efficient basic information and data source for continuing education and research;
5. The record serves to assist in "protecting the legal interest of the patient, the hospital, and the responsible practitioner". (Jt. Commission Accreditation Manual 1976, p. 93)

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[2]Some prisons maintain two or three medical records rather than the more desirable unit record, i.e., one medical record per prisoner.

[3]The health team concept includes physicians, nurses and allied health care professionals, medical record practitioners, including clerical staff, and the prisoner. Depending on the particular philosophy of the health care professionals and the prison administration the prison may or may not have direct access to the record. The prisoner should, of course, be informed of what is in the record, whether or not direct access is permitted.

Iv. Managing the Record System. Given these statements of purpose, what then are the basic management principles to be observed in prison settings when the POMR system is to be instituted?

First, the record should be separate from the confinement file and should be stored near the center of clinical services.

Second, if at all possible, all medical records should be kept in one file folder--that is, the in-patient record, the sick call or out-patient record, and the mental health record should be kept together.

Third, medical records should be safeguarded so that confidentiality is protected and only authorized persons will have access to them. (Note: In prison health care it is important to assure confidentiality, which means denying access to records by other prisoners as well as other unauthorized persons.)

Fourth, in inter-institutional transfers the health care record should accompany the prisoner. In transfers across jurisdictions (e.g., state to federal institutions) appropriate transfer summaries should accompany the prisoner.

Fifth, there should be documentation of every patient-practitioner encounter, regardless of the locale or time of the service. That is, even if sick call is held in the cell blocks there should be a structured record of each contact.

Sixth, the medical record should be pulled and reviewed every time a patient is seen.

If these simple principles are adhered to, the medical record will become a useful and helpful tool for both clinical and managerial purposes, thereby making the work of the health care team more responsible and effective.

USING THE PROBLEM ORIENTED MEDICAL RECORD MANUAL

This manual has been designed to accomplish two major ends, namely: to give the prison health care professional a convenient reference for understanding the problem oriented medical record approach, and to give people who will have responsibility for medical records a step-by-step model that will help them implement the process in prison settings.[4]

To make the best use of the manual, the reader should review the overview chapter, particularly the management principles cited therein, then work through the second chapter which deals with the basic concepts of POMR. It is advisable for the reader who has had little exposure to problem oriented record keeping to actually work through some of the case examples and to call upon the technical assistance of people who have had some experience with POMR systems to answer specific questions.

More experienced people will find the material in Chapter 2 illustrative of the uniqueness of prison health care settings, and will be struck by the fact that much emphasis is placed on ambulatory care as opposed to in-patient care (i.e., use of diagnostic protocols, etc.) nonetheless much of the care given centers around the "sick call" and ambulatory care.

Chapter 3 of the manual serves as a sequential map for implementing the POMR system in any given prison. The steps follow the traditional program planning model leading from knowing the environment through engaging a core group of staff to helping them build a system for their own setting.

This process is <u>people oriented</u>. It cannot be done in a mechanical fashion, but must constantly take into account the readiness of people to make changes, the values that motivate them, and the benefits that may accrue to them if they do elect to move to a POMR system. That is, people don't change because they are told to; they change because they want to.

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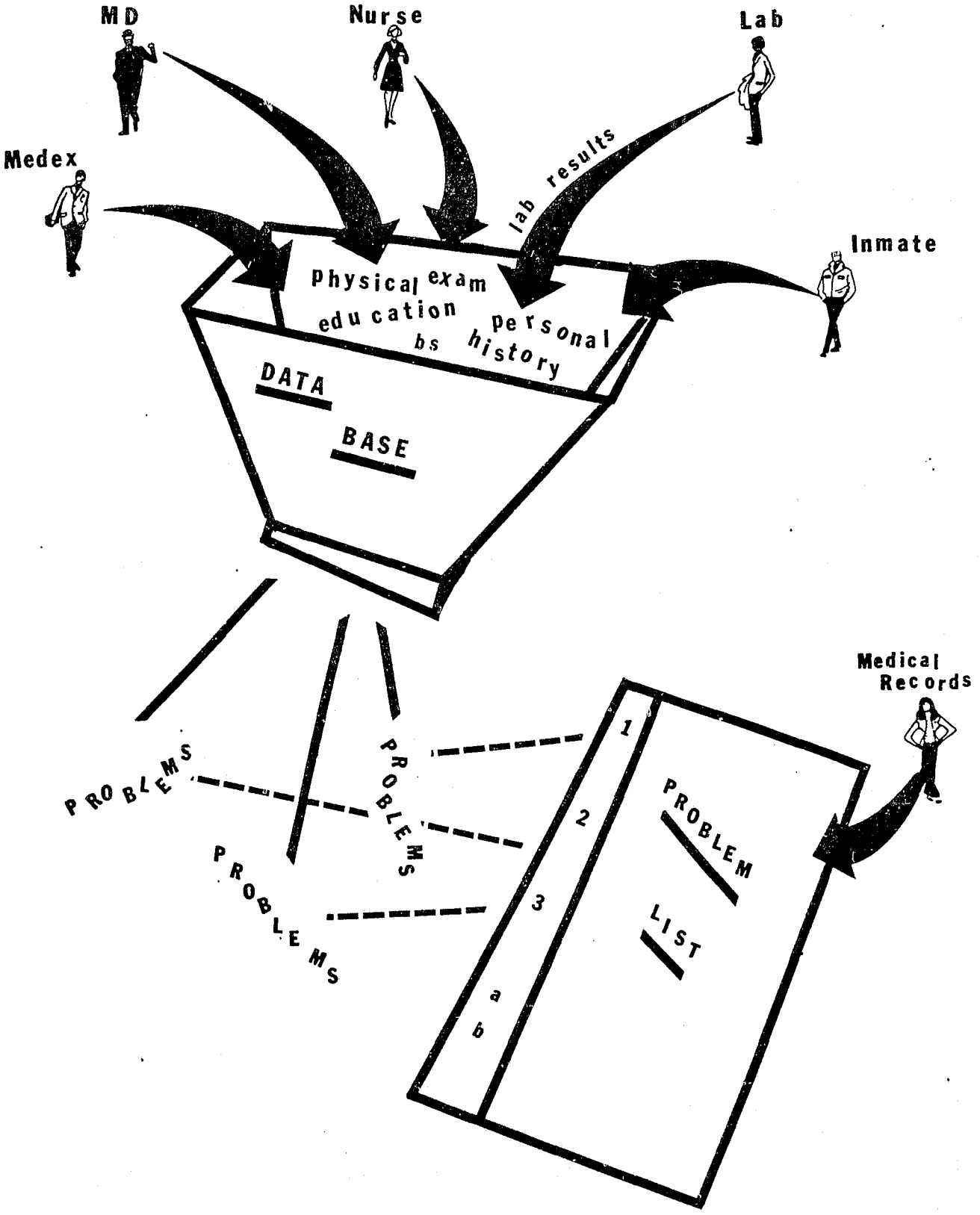
[4]This manual deals only with POMR systems and prisons--jails and other types of correctional settings present unique demands not dealt with here.

The material in this chapter should be read several times before attempting to apply it. Then if in doubt call upon the outside technical experts. POMR systems are technically very simple but interpersonally very complex, so unless you are sure of your interpersonal skills don't hesitate to ask for help.

Finally, a brief bibliography is provided to direct you to some useful source material that may help you when problems arise and the experts aren't around. The bibliography has purposely been kept brief in the hope that it will be used and will prove helpful.



POMR: the TECHNICAL PROCESS

CHAPTER 2

POMR: THE TECHNICAL PROCESS

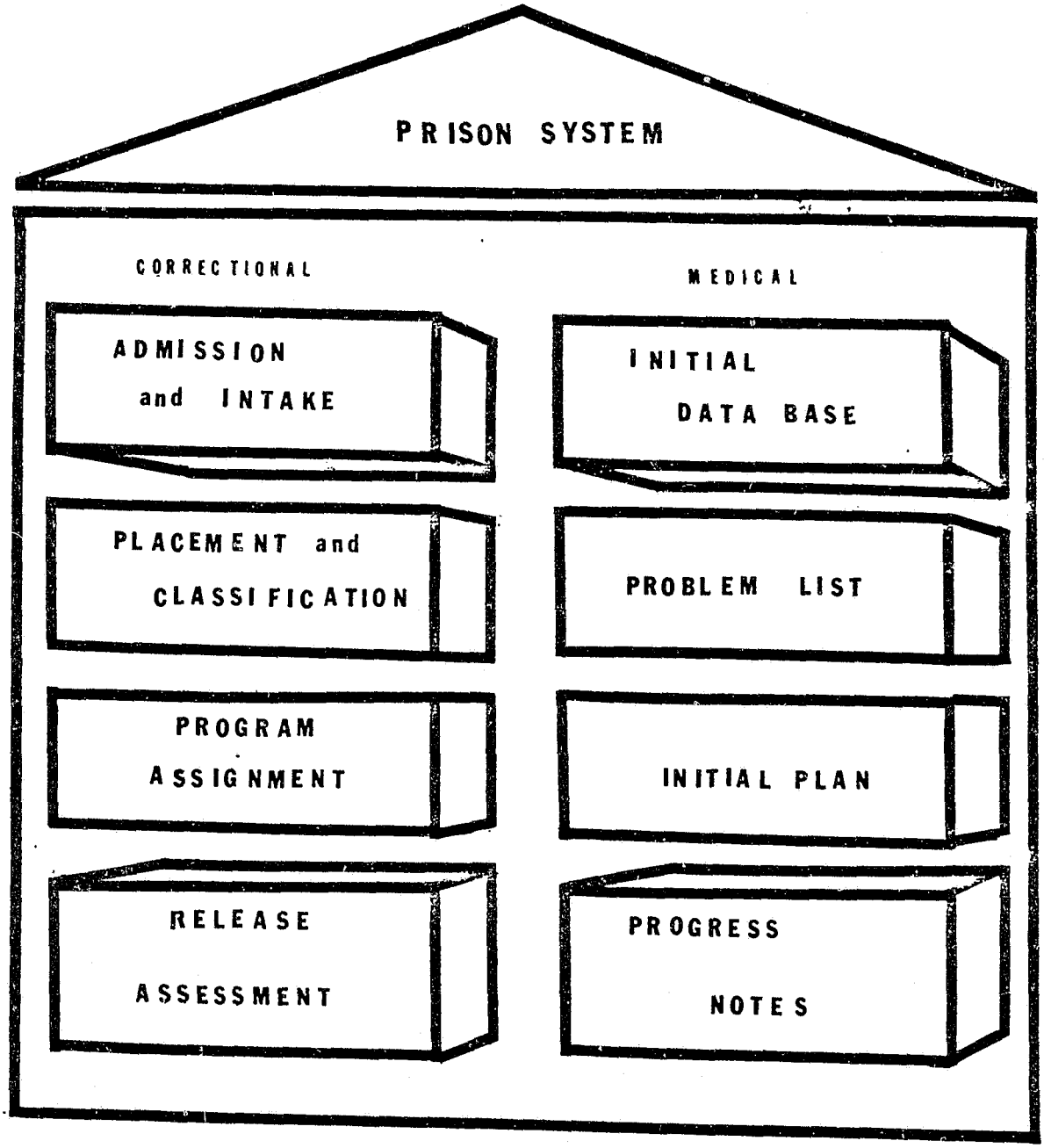
Problem Oriented Medical Record keeping provides a logical way of documenting a prisoner's health care because it builds on concepts and practices which already exist in your prison.

To understand and then to practice the POMR entails nothing more than viewing what is already happening to a prisoner as (s)he moves through your institution and your health care system. Remember that the POMR has four basic components:

1. Initial Data Base
2. Problem List
3. Initial Plans
4. Progress Notes

As an offender enters a prison, a paper trail is created which attempts to record the important, and sometimes not so important, events which occur during his incarceration. There are elements in that trail which can be identified with the four basic components of the POMR as shown in Figure 1.

FIGURE 1



Prisoner Flow Through Prison System

CORRECTIONAL DATA BASE

Admission and Intake

-gathers information to assess the offender's background and present circumstances

-includes birthplace, social background, education, employment history, and attitudes

-may be collected by general staff under supervision of trained correctional staff

-includes a mental assessment

Placement and Work Classification

-developing additional information by extending testing and screening

-decision making process for development of correctional program for offender

-helps determine level of security for offender

MEDICAL DATA BASE

Initial Data Base

-collects standardized health information on each prisoner

-includes history, physical examination, laboratory tests, etc.

-collected by members of the health care team

Problem List

-lists of prisoner's health problems

-indexes the medical record by titling, numbering, and dating identified problems

-provides perspective on past, present, and possible future problems

-developed by all health care team members

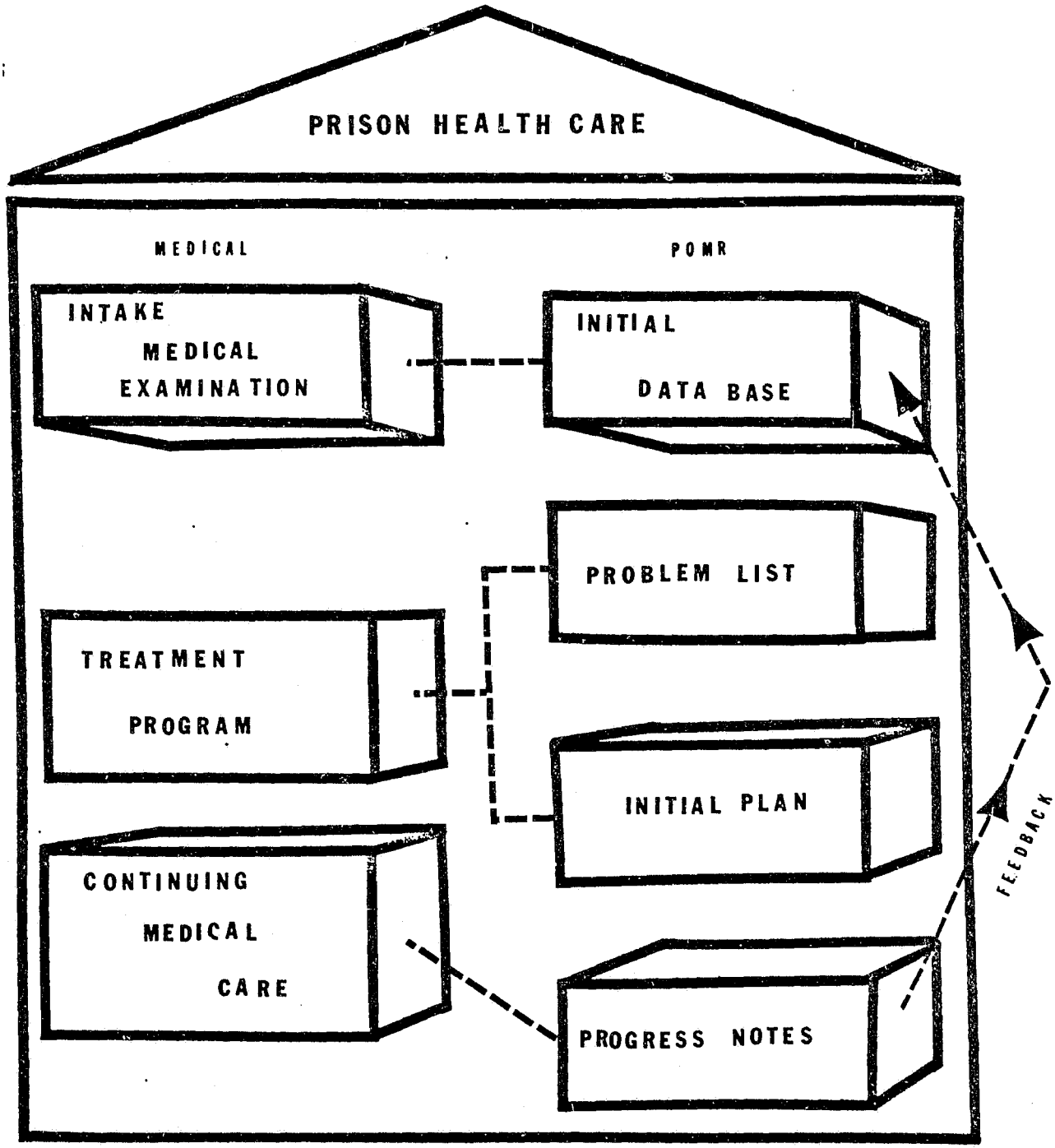
-clarifies communication among the health care team

CORRECTIONAL	MEDICAL
Assignment to Prison Program	Initial Plan
-developing a program for each offender	-developing a plan for resolving identified problems
-shared written and oral presentations by staff teams for educational, vocational and work assignments	-includes problem number, and course of action for the problem
-developed by correctional professionals	-developed by health care team members
Review and Assessment for Release	Progress Notes
-continuous evaluation of offender's progress in program	-details the followup to the problem
-developing liaison with community resources to devise release program	-always identified by the number or letter originally assigned
-assessment of the capability of the offender and the community to accept his return to society	-includes four parts: Subjective--data obtained from the patient, friends, custody Objective--clinical and laboratory findings Assessment--appraisal based on subjective and objective data Plan of Management--treatment, patient education, and if indicated, further development of information

As can be seen, the POMR is much more structured than records developed for the correctional program.

The usefulness of the POMR is appreciated when one understands the movement of a patient through the prison health care system. The left column of Figure 2 displays a prison health care model, while the right column associates the POMR components.

FIGURE 2



PRISONER FLOW

THROUGH

PRISON HEALTH CARE SYSTEM

INITIAL DATA BASE

The objective of the Initial Data Base is to build a foundation from which problems can be identified. The POMR begins with a precisely defined body of information gathered on each resident during the intake evaluation. Although it is important for your health care team to define a Data Base specific to your situation, these elements are invariably included:

1. Patient demographic information: name, alias, resident number, date of birth, sex, ethnic background
2. Patient medical history
3. Physical exam
4. Laboratory tests

Because the data to be gathered is defined in advance, it becomes possible to obtain the same data on every resident entering your prison system.

Personnel other than physicians may collect parts of the data, especially if the data is precisely defined by printed forms and guidelines are provided for the interviewer and the patient.

Examples of a prison history and physical exam follow. These are examples only, you will want to develop your own Data Base forms in your institutional setting according to the special needs of that setting. See Chapter 3 "Steps to Achieving Quality Medical Records in Prisons" for further clarification of this process.

INITIAL MEDICAL HISTORY

SAMPLE

1. RESIDENT NAME (LAST - FIRST - MIDDLE INITIAL)	2. RESIDENT NUMBER	3. BIRTHDATE	4. FACILITY	5. DATE

6. PLACE OF BIRTH (CITY & STATE)	7. SEX ☐ MALE ☐ FEMALE	8. RACE	9. RELIGION

10. SIGNIFICANT FAMILY ILLNESSES

11. PAST HISTORY (ILLNESSES, SURGERY, HOSPITALIZATIONS, MENTAL ILLNESS) CHECK IF APPLICABLE:

	DATE
01 ☐ SEIZURES	
02 ☐ DIABETES	
03 ☐ HYPERTENSION	
04 ☐ TUBERCULOSIS	
05 ☐ HEPATITIS	
06 ☐ MENTAL ILLNESS	
07 ☐ ASTHMA	
08 ☐ UNCONSCIOUSNESS	
09 ☐ GONORRHEA	
10 ☐ SYPHILIS	
11 ☐ RHEUMATIC FEVER	
12 ☐ SCARLET FEVER	
13 ☐ MUMPS	

14 ☐ OTHER (LIST):

LIST OPERATIONS, ACCIDENTS, UNCONSCIOUSNESS

12. IMMUNIZATIONS	YEAR
1 POLIO	
2 TETANUS	
3 DIPHTHERIA	
4 SMALL POX	

13. SENSITIVITIES - DRUG
INHALANT CONTACT

14. ALCOHOL AND OTHER SUBSTANCE ABUSE

15. SERVICE IN ARMED FORCES
1 ☐ MILITARY SERVICE 2 ☐ MEDICAL DEFERMENT 3 ☐ MEDICAL DISCHARGE 4 ☐ OTHER (SPECIFY):

16. PRESENT PHYSICAL COMPLAINT

17. CURRENT MEDICAL TREATMENT

18. LOCATION OF EXISTING HEALTH RECORDS

SIGNATURE _____ PROVIDER NO. _____ DATE _____

☐ ENTRY EXAMINATION

☐ OTHER

PHYSICAL EXAMINATION

SAMPLE

1. RESIDENT NAME (LAST - FIRST - MIDDLE INITIAL)	2. RESIDENT NUMBER	3. BIRTHDATE	4. FACILITY	5. DATE

6. TEMPERATURE	7. PULSE BPM	8. RESPIRATION BREATHS PER MIN.	9. WEIGHT LBS.	10. HEIGHT FT. IN.	11. BLOOD PRESS. /	12. DATE NEXT EXAM DUE

13. VISION

	CORRECTED	UNCORRECTED
RIGHT	/	/
LEFT	/	/

COLOR VISION (ADC):

14. HEARING

1. ☐ LEFT 2. ☐ RIGHT HEARING AID ☐ YES ☐ NO

AUDIOMETRIC:

CHECK ITEM IF ABNORMAL:

15 ☐ SKIN	21 ☐ NOSE	27 ☐ BREASTS	33 ☐ MUSCULOSKELETAL	39 ☐ URINE	44 ☐ SMA-12
16 ☐ GAIT	22 ☐ EARS	28 ☐ LUNGS	34 ☐ EXTREMITIES	40 ☐ HCT	45 ☐ EKG
17 ☐ SPEECH	23 ☐ THROAT	29 ☐ HEART	35 ☐ NEUROLOGICAL	41 ☐ SEROLOGY	46 ☐ SICKLE CELL
18 ☐ SCALP	24 ☐ MOUTH	30 ☐ ABDOMEN	36 ☐ LYMPH NODES	42 ☐ CHEST X-RAY	47 ☐ G. C. CULTURE
19 ☐ EYES	25 ☐ NECK	31 ☐ GENITALIA	37 ☐ RECTUM	43 ☐ LIVER FUNCTION	48 ☐ PAP SMEAR
20 ☐ FUNDI	26 ☐ CHEST	32 ☐ SPINE	38 ☐ PELVIC		

49. ABNORMAL FINDINGS (REFER TO ABOVE NUMBERS)

50. MENTAL STATUS / BEHAVIORAL ASSESSMENT

51. FUNCTIONAL LIMITATIONS

SIGNATURE PROVIDER NO. DATE

Problem List

The Problem List is a display of problems affecting the resident's health status. Because the Problem List is an index to the contents in the records, it should be immediately visible when the record is opened. Each problem is numbered or lettered, titled and dated. The Problem List is compiled by the health care team from the Initial Data Base and from subsequent patient encounters at sick call or during an inpatient stay. Problems identified during the intake medical evaluation are listed at that time. Subsequent problems identified at sick call or during an inpatient stay are listed on the Problem List and a Progress Note is written.

Medical, social, and psychiatric problems of prison residents are either major or minor. Major problems are those which significantly affect a resident's health. Examples include diabetes, depression, paraplegia, and seizure disorder. Each major problem has a problem number, title, date entered, person entering and, if desired, a space to code the problem.[1] The Initial Plan and Progress Notes concerning that problem are headed by that problem's number and title.

Minor problems are those which will probably not affect the overall health of the patient. These problems are self-limiting and may include headache, low back pain, or URI cough. Minor problems are identified by problem letter, title, and dates of reoccurrence.

Problems are identified by members of the health care team and listed at the level of his/her understanding. Recognizing a medical problem may be on one of four levels:

1. Symptom or physical finding (back pain, wheezing, shortness of breath);
2. Abnormal laboratory findings (abnormal CBC, positive VDRL);
3. Physiologic findings (congestive heart failure);
4. Diagnosis (diabetes mellitus).

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[1]Coding allows specific medical records to be retrieved through data listed in problem, disease, operation, and/or practitioner indexes. It then becomes possible to do research and retrospective evaluation on prison health care.

"Rule outs" or questionable diagnoses do not belong on the Problem List; they belong in the Initial Plan or in the Plan in the S.O.A.P. Progress Notes.

Psychiatric and social problems of the prisoner should be entered on the list in a clearly stated manner, e.g. paranoid schizophrenia, triple bunked in house. If a mental health program of your prison is separate from the medical services, both the medical and mental health record should have the same Problem List attached to each.

When problems are further diagnosed or resolved, the Problem List is amended with a dated arrow:

PROBLEM LIST

MAJOR PROBLEMS: (require follow-up as may significantly affect health.)

6. DATE LISTED	7. NO.	8. PROBLEM	9. PROVIDER (NAME AND CODE)	10. PROBLEM CODE	11. INACTIVE DATE
2/28/78	1	Shortness of breath —(8/2/78)→ CHF	G. Jones, M.D.		
4/11/78	2	Pneumonia	P. Wirth, P.A.		

TEMPORARY PROBLEMS (self-limiting)

12. LETTER	13. PROBLEM	14. CODE	15. DATE OF EACH RECURRENCE									
A	URI —(4/11/78)→ Pneumonia see Problem #2		3/21/78	3/8/78	4/5/78	4/9/78						

Even though the problem is resolved, problem #1 is always congestive heart failure and the number is never used again. If a temporary problem becomes a major problem, the same technique is used, as shown in the second example above.

The Problem List should be reviewed by the health care professional each time the medical record is opened. The following is an example of a Problem List:

ADULT CORRECTIONS
DIVISION

LIST

1. RESIDENT NAME (LAST – FIRST – MIDDLE INITIAL)	2. RESIDENT NUMBER	3. BIRTHDATE	4. FACILITY	5. DATE

MAJOR PROBLEMS: (require follow-up as may significantly affect health.)

6. DATE LISTED	7. NO.	8. PROBLEM	9. PROVIDER (NAME AND CODE)	10. PROBLEM CODE	11. INACTIVE DATE

TEMPORARY PROBLEMS (self-limiting)

12. LETTER	13. PROBLEM	14. CODE	15. DATE OF EACH RECURRENCE									

DSHS 13-378(7-78)

INITIAL PLANS

When the Initial Data Base has been gathered and if any problems are identified, the physician will decide to take a specific course of action. This plan may include gathering more information, diagnostic workups, treatment, follow-up care, and patient education. Each problem requires a separate plan except, of course, if the management is the same for several problems.

After the initial medical evaluation of a resident, most often there will be no need for an Initial Plan unless problems have been identified. When a resident is admitted as an inpatient in the institution, however, an Initial Plan should be generated to document intended management of the problem(s).

PROGRESS NOTES

Progress Notes are the core of the prison medical record because they document patient/practitioner encounters at sick call. Ambulatory care or sick call is where most prison medicine is practiced. The POMR Progress Notes generated at sick call are structured to capture information in a meaningful fashion. They contain:

1. Date and time
2. Problem number or letter
3. Problem title or chief complaint if problem is not yet identified
4. The S.O.A.P. format:
   S - Subjective data
   O - Objective data
   A - Assessment of S and O data
   P - Plan

Subjective data — is information gathered from the resident, custody, and friends or family about the patient;

Objective data — is information from clinical and laboratory findings of the health care team;

Assessment — of the S and O explains their significance and what the health professional thinks about the problem's management. It should lead to the formulation of a plan.

Plan — for course of action. The Plan may include gathering more information, treatment, and patient education.

Examples of problem oriented sick call Progress Notes are as follows:

7/24/78 #3 Neurotic depression (previously identified problem)

S. Feels better. Considering divorce after he gets out. Still can't communicate with wife on visits or in his letters.

O. Thinking clearly. Considering divorce.

A. Significant depression. Not suicidal.

P. Following parole next month, conjoint counseling at community health center.

John Jones, M.D.

5/19/78 c.c. "Cold"

S. Coughing all the time, feels stuffed up, chest pain, smokes one pack of cigarettes per day.

O. T 101, P. 85, BP 104/68, throat is clear, slight nasal discharge.

A. URI.

P. ASA. Lay-in. Return on 5/21/78.

Janet Pickett, P.A.

In the second example, the assessment would be entered on the Problem List under "Temporary Problems" and succeeding visits for the same problem would be dated in the same way. A S.O.A.P. Progress Note should be written to correspond to any date on the Temporary Problem List.

FLOW SHEETS

For patients with problems requiring comparison of multiple variables over time (medications, blood sugar levels, blood pressure readings,

weight), it may be useful to construct a flow sheet. Problems which lend themselves to flow sheets include hypertension, diabetes, and pre-natal care. The variables or factors being measured are noted across or down the page with the dates listed in the opposite direction. There are several ways of formating this data. The direction of the information depends on the edge at which the record is bound (top or side), the record container or folder, and the number of variables used. Flow sheets may be either general purpose or specific to a problem. Examples of a general purpose flow sheet, one for diabetes and one for hypertension, and shown on the following pages. The parameters or variables to be noted are determined by the health care team. It should be designed and documented so that multiple variables can be compared and quickly indicate the patient's course. Any significant information in the flow chart should be indicated in the objective part of the Progress Notes for any problem they effect either by copying the finding in the note or simply by "See Flow Chart".

Progress Notes

5/30/78 #1 Diabetes Mellitus
#2 Pyelonephritis, Chronic

S. No complaints.
O. See Flow Chart.
A. #1 controlled. #2 requires continuing observation.
P. Return in one month for FBS and urine culture.

Discharge Summary

The discharge summary is an overview of the hospital course and is completed at the end of an inpatient hospitalization. A summary is written for each problem and follows the S.O.A.P. format:

S. Patient's chief complaints on admission;
O. Physical exam and laboratory reports at admission and during the hospital course;
A. Clinical course and treatment outcomes, prognosis;
P. Follow-up management, further diagnostic work, medications, patient education, date to be seen on sick call.

An example of a discharge summary is:

S. The patient was admitted to the infirmary complaining of chills, fever, and sore throat.

O. T 103.5; throat markedly inflamed. Culture showed streptococci sensitive to Ampicillen.

A. Bed rest and forced fluids, 500 mg. Ampicillen. Rapid response to medication. Patient discharged to population, afebrile.

P. Make appointment for sick call if fever returns.

L.P. Jones, M.D.

STD. FORM C4

GENERAL PURPOSE FLOW SHEET

INSTRUCTIONS: Label problems at top and enter parameters to be followed: H&P; Measurements: Lab data; Blood pressures, etc.

PROBLEM:

#1 Diabetes Mellitus

#2 Pyelonephritis, Chronic

PARAMETERS	6-14	6-15	6-16	DATES/TIME 17	6-18	6-19	6-20
BLOOD SUGAR	345 mg%	325 mg%	300 mg%	290 mg%	250 mg%	220 mg%	250 mg%
URINE ACETONE	+++	+++	++	+	–	–	–
URINE ALBUMIN	3+	3+	2+	1+	0	0	0
URINE SUGAR	4+	4+	2+	2+	2+	2+	2+
BUN	49	—	48	—	46	46	—
CREATININE	1.6	—	6.4	—	5.9	—	—

STAMP HERE

LAST NAME	FIRST	INITIAL	
Wilson	Ardvard	M.	32-79-45
PHYSICIAN			
Barnes			87*
BIRTH DATE		AGE	
9-18-16	Male		315

MEDICAL RECORD

FLOW SHEET

DIABETIC

SPECIAL PROBLEMS / Recorder's Signature	DATE	4 hr. Glucose	FBS	WEIGHT	BP	P	Urine S	Urine A	INSULIN

COMMENTS: (Include date and signature)

Name:

No:

Office of Health Care

MEDICAL RECORD

FLOW SHEET

HYPERTENSION

SPECIAL PROBLEMS	DATE	BP	P	K	WEIGHT	MEDICATIONS	SIGNATURE

COMMENTS: (Include date and signature)

Name:

No:

PRACTICE EXAMPLES

I. Problem List and Initial Plan.

Using the following case history, develop a Problem List and Initial Plan from your own level of understanding. After completing all practice examples, see suggested solutions.

Case History:

A newly arrived resident is a 24-year old black male complaining of "skin problems" for 4 - 5 years and not feeling well for three weeks.

He had the usual childhood diseases with no complications, but had always been a "different" boy. He was hospitalized for six months when he was 18 for a "nervous breakdown". There have been no emotional problems since then, but he has often felt people "bugged" him and he preferred his own company. Three weeks ago he spent 5 days in bed because of an attack of weakness, muscle pains, fever, and discomfort in the upper abdomen. He had no appetite and ate practically nothing during that period. At present he does not feel entirely well, but his appetite is better.

He is one of five siblings. His father disappeared when he was three and his mother works sporadically as a domestic. He speaks of her only as a large woman with white hair. Two brothers are in prison, one sister is in a mental hospital, and one sister is reported as well and happily married.

On physical examination he appeared withdrawn and smiled briefly several times for no apparent reason. There was no evidence of recent weight loss. Temperature was 98.8, pulse was 74, regular, BP 165/94, respirations 12. He is 170 inches tall and weighs 155 pounds. Sclerae were slightly yellow. Many teeth had cavities and the gums were spongy and friable. Tonsils were enlarged but did not appear infected. Skin examination revealed irregular, rounded areas, elevated, red and covered with white scales which easily flaked. These areas were on extensor surfaces of forearms and across the upper abdomen. Examination of the abdomen revealed a tender liver edge extending 1½ finger breadths below the costal margin. The rest of the physical exam revealed no abnormalities.

Mental Status Assessment: Resident was moderately withdrawn, oriented as to person, time, and place. Smiled inappropriately several times and did not speak spontaneously.

Positive Lab Findings: Serum bilirubin 6 mg/dl
SGPT 70 units

2. S.O.A.P. and the Problem List

Using the following case histories, construct a Problem List for each case. Since both of these patients were originally seen on sick call, you must S.O.A.P. the encounters, identify problems, and list them. (Remember, there is more than one encounter in each case.)

Case A:

June 1, 1977. A 25-year old white male appearing well nourished and in generally good health complains of a sudden onset of severe frontal headache of four hours duration. The headache is described as "bursting" and "intolerable." There is no history of previous headaches. At the onset of the headache, his side vision became impaired. It was as though "horse-blinders" had been put on him.

Positive finding on physical examination: loss of bi-temporal vision on confrontation by moving fingers.

Initial Impression:

1. Ruptured cerebral aneurysm, near optic chiasm. Plan: Emergency consult with neurosurgeon. Spinal tap.

Progress Notes: 6/2/78

Spinal tap yielded moderately bloody fluid at 250 mm H_2O pressure.

Spinal tap repeated four hours later by a neurosurgeon showed grossly bloody fluid. A cerebral angiogram revealed several "berry aneurysms" with evidence of leakage in area of optic chiasm. Initial diagnostic impression was confirmed.

Emergency craniotomy discovered a ruptured aneurysm of the anterior communicating cerebral artery. This vessel was tied off, and the operative wound closed. Patient recovered uneventfully.

Case B:

June 1, 1977. A 40-year old male complains of chills, fever, muscle aches, general weakness, and shortness of breath for four days duration. Significant findings on physical examination: ill-appearing male, profusely perspiring, with no evidence of recent weight loss. Temperature 102.8, pulse 124, regular. There is a blowing grade IV diastolic murmur which extends throughout diastole. There are slightly increased crepitations throughout lung fields and splinter hemorrhages in several fingernail beds. Several recent needle marks are seen in the skin in the antecubital fossa.

Initial Impression:

1. Bacteremia, caused by self-administered intravenous introduction of an unknown substance.
2. Mycotic involvement of pulmonary valves
3. Bacterial pneumonitis, diffuse.

Plan:

1. Blood culture with sensitivities to antibiotics.
2. Chest film.
3. ECG.

Initial Lab Reports:

1. Blood culture: many colonies of short chain gram positive cocci, sensitive to Ampicillen.
2. Chest film: fullness of right cardiac border, diffuse areas of infiltration of lung fields.
3. ECG: right heart strain.

Diagnosis:

1. Bacteremia, caused by contamination, self-administered injection of unknown substance.
2. Mycotic involvement of pulmonary valves.
3. Pneumonitis, patchy, bacterial.
4. Mild/moderate rightsided congestive failure.

Treatment:

1. Admit to infirmary, close observation (possible rupture of a pulmonary valve).

2. Ampicillin, 500 mg, q.i.d.
3. Thiazide diuretics.

Excerpts of Progress Notes:

July 1, 1977. Shortness of breath on exertion. Bacteremia and pneumonitis definitely cleared. Heart murmur unchanged. Cardiac silhouette by x-ray shows prominence of right heart border. Hilar congestion.

Venous pressure 80 mm H_2O.

ECG shows definite right ventricular hypertrophy.

Treatment: Digitalize. Change thiazide to mercurial diuretics. Low salt diet.

January 2, 1978. Shortness of breath climbing flight of stairs. Evaluation by cardiac function study group at University of Washington Medical Center yields recommendation for open heart surgery and transplant of porcine heterograph.

March 1, 1978. Open heart surgery as recommended by Cardiac Study Group.

May 25, 1978. Clinically well. ECG continues to show evidence of right ventricular hypertrophy.

Plan: See prison physician once a month. No medication. No restrictive activities. Check back in six months.

1. CASE SOLUTION:

SAMPLE PROBLEM LIST

MAJOR PROBLEMS: (require follow-up as may significantly affect health.)

6. DATE LISTED	7. NO.	8. PROBLEM	9. PROVIDER (NAME AND CODE)	10. PROBLEM CODE	11. INACTIVE DATE
June 1, 1978	1	Hypertension, moderate	M.A. Negretti, M.D.		
June 1, 1978	2	Psoriasis	M.A. Negretti, M.D.		
June 1, 1978	3	Hepatitis, infectious	M.A. Negretti, M.D.		
June 1, 1978	4	Dental caries, chronic gingivitis	M.A. Negretti, M.D.		

INITIAL PLAN

Problem #1 - Hypertension

Check blood pressure weekly

Problem #2 - Psoriasis

5% coal tar ointment with ultra violet radiation

Problem #3 - Hepatitis

Admit to infirmary for observation

Problem #4 - Dental caries, chronic gingivitis

Refer to Dr. Brown (dentist)

Problem - Schizophrenia, latent?

Mental status assessment

M.A. Negretti, M.D.
6/1/78

DIVISION

1. RESIDENT NAME	2. RESIDENT NUMBER
3. FACILITY	

SAMPLE

2. CASE A SOLUTION:

6/1/78 c.c. "headache"

S. Intolerable, bursting, frontal headache for four hours. Vision impaired as if horse blinders had been put on.

O. Loss of bitemporal vision on confrontation by moving fingers. Elevated spinal fluid pressure. Bloody spinal fluid.

A. Ruptured cerebral aneurysm, near optic chiasm.

P. Admit to hospital. Spinal tap. Emergency consult with neurosurgeon.

L. P. JONES, M.D.

6/2/78 Problem #1, ruptured cerebral aneurysm

S. Intolerable, bursting frontal headache for four hours. Vision impaired as if horse blinders had been put on.

O. Spinal tap yielded moderately bloody fluid. Spinal fluid pressure 250 mm H_2O. Neurosurgeon confirmed diagnostic impression on repeat spinal tap four hours following admission which showed grossly bloody fluid. Cerebral angiogram revealed several "berry aneurysms" with evidence of leakage in area of optic chiasm.

A. Ruptured aneurysm of the anterior communicating artery.

P. Emergency craniotomy.

L. P. JONES, M.D.

In the first Progress Note, the patient is being seen on a referral from sick call. He is still an outpatient. The second Progress Note by the same physician, L. P. Jones, is written after admission to the hospital and consultation with the neurosurgeon. The operative report of a neurosurgeon would be much longer and more complete.

PROBLEM LIST:

The "headache" could have been placed on the Temporary Problem List if there had been a history of previous headaches. It is placed on the Major Problem List because it is an initial severe headache associated with bloody spinal fluid.

SAMPLE PROBLEM LIST

MAJOR PROBLEMS: (require follow-up as may significantly affect health.)

6. DATE LISTED	7. NO.	8. PROBLEM	9. PROVIDER (NAME AND CODE)	10. PROBLEM CODE	11. INACTIVE DATE
6/2/78	1	Ruptured aneurysm	L.P. Jones M.D		

DEPARTMENT OF SOCIAL & HEALTH SERVICES
ADULT CORRECTIONS DIVISION

PROGRESS NOTES

1. RESIDENT NAME	2. RESIDENT NUMBER
3. FACILITY	

SAMPLE

2. CASE B SOLUTION:

6/1/78 (patient seen on sick call)
c.c. "feels like I have the flu"

S. Chills, fever, muscle aches, general weakness and shortness of breath for four days, no recent weight loss

O. Profusely perspiring, T 102.8°, P 124 regular. Blowing grade IV diastolic murmur throughout diastole. Slightly increased crepitations throughout lung fields and splinter hemorrhages in several fingernail beds. Recent needle marks in skin of anticubital fossa.

A. Bacteremia caused by self-administered I.V. introduction of unknown substance. Mycotic involvement of pulmonary valves. Bacterial pneumonitis, diffuse.

P. Admit to hospital, close observation. Blood culture with sensitivities to antibiotics.
Chest film.
ECG.
Ampicillen 500 mg qid.
Thiazide diuretics.

L. P. JONES, M.D.

The Problem List is as follows:

SAMPLE PROBLEM LIST

MAJOR PROBLEMS: (require follow-up as may significantly affect health.)

6. DATE LISTED	7. NO.	8. PROBLEM	9. PROVIDER (NAME AND CODE)	10. PROBLEM CODE	11. INACTIVE DATE
6/3/78	1	Bacteremia	L.P. Jones MD		7/1/78
6/3/78	2	Bacterial Endocarditis	L.P. Jones MD		
6/3/78	3	Pneumonitis	L.P. Jones MD		7/1/78
6/3/78	4.	Congestive Heart Failure	L P Jones MD		

DEPARTMENT OF SOCIAL & HEALTH SERVICES
ADULT CORRECTIONS DIVISION

SAMPLE

PROGRESS NOTES

1. RESIDENT NAME	2. RESIDENT NUMBER
3. FACILITY	

2. (CASE B continued)

Excerpts of Progress Notes:

7/1/77 Problem #2 Bacterial Endocarditis
Problem #4 Congestive Heart Failure

S. Shortness of breath on exertion.

O. Diastolic murmur, essentially unchanged. Venous pressure 80 mm H_2O. ECG: right ventricular hypertrophy.

A. CHF, insufficiency of pulmonary valves.

P. Digitalize on Digoxin. Start mecurial diuretics. Instruct patient in low salt diet.

R. SMITH, P.A.

1/2/78 Problem #2 Bacterial Endocarditis
Problem #4 Congestive Heart Failure

S. Shortness of breath on climbing one flight of stairs.

O. See extensive report of findings and recommendations of cardiac study group.

A. Gradually increasing tricuspid insufficiency.

P. Open heart surgery and transplant tricuspid prosthesis.

P. S. GRAL, M.D.

DEPARTMENT OF SOCIAL & HEALTH SERVICES
ADULT CORRECTIONS DIVISION

PROGRESS NOTES

1. RESIDENT NAME	2. RESIDENT NUMBER
3. FACILITY	

SAMPLE

2. (CASE B continued)

3/1/78 Problem #2 Bacterial Endocarditis
Problem #4 Congestive Heart Failure

P. Tranfer to U of W for open heart surgery.

M. GREEN, M.D.
Medical Director

5/25/78 Problem #2 Bacterial Endocarditis
Problem #4 Congestive Heart Failure

S. Feeling well. No complaint. No shortness of breath.

O. P 74 regular, BP 125/86. No murmurs.
ECG shows evidence of right ventricular preponderance.
Cardiac silhouette smaller.

A. Satisfactory post-surgical course. No complications.

P. No medication. No restrictive activities. Return visit in 2 weeks. Reevaluate at U of W August 8, 1978.

P. S. GRAL, M.D.

CHAPTER 3

STEPS TO ACHIEVING QUALITY MEDICAL RECORDS IN PRISONS

Bringing about change from one system to another in custodial institutions is a task that requires understanding about what is to be changed, what the new product should look like, and perhaps most importantly who the people are who will be involved in the change.

When the change to be achieved involves changing people's way of working, as in a change from one type of record keeping to another, the person directing that change must contend with at least two important tasks, namely:

(1) helping people to learn the new technical process, and

(2) helping people to give up old methods of working in exchange for the new approach.

Teaching the technical process is relatively simple and straight-forward. Getting people to do things differently is much more complex.

In this part of this manual, you will be given a practical model for conducting change efforts where the goal is to introduce a problem oriented medical record system as an essential communication tool for all of the prison health care team.

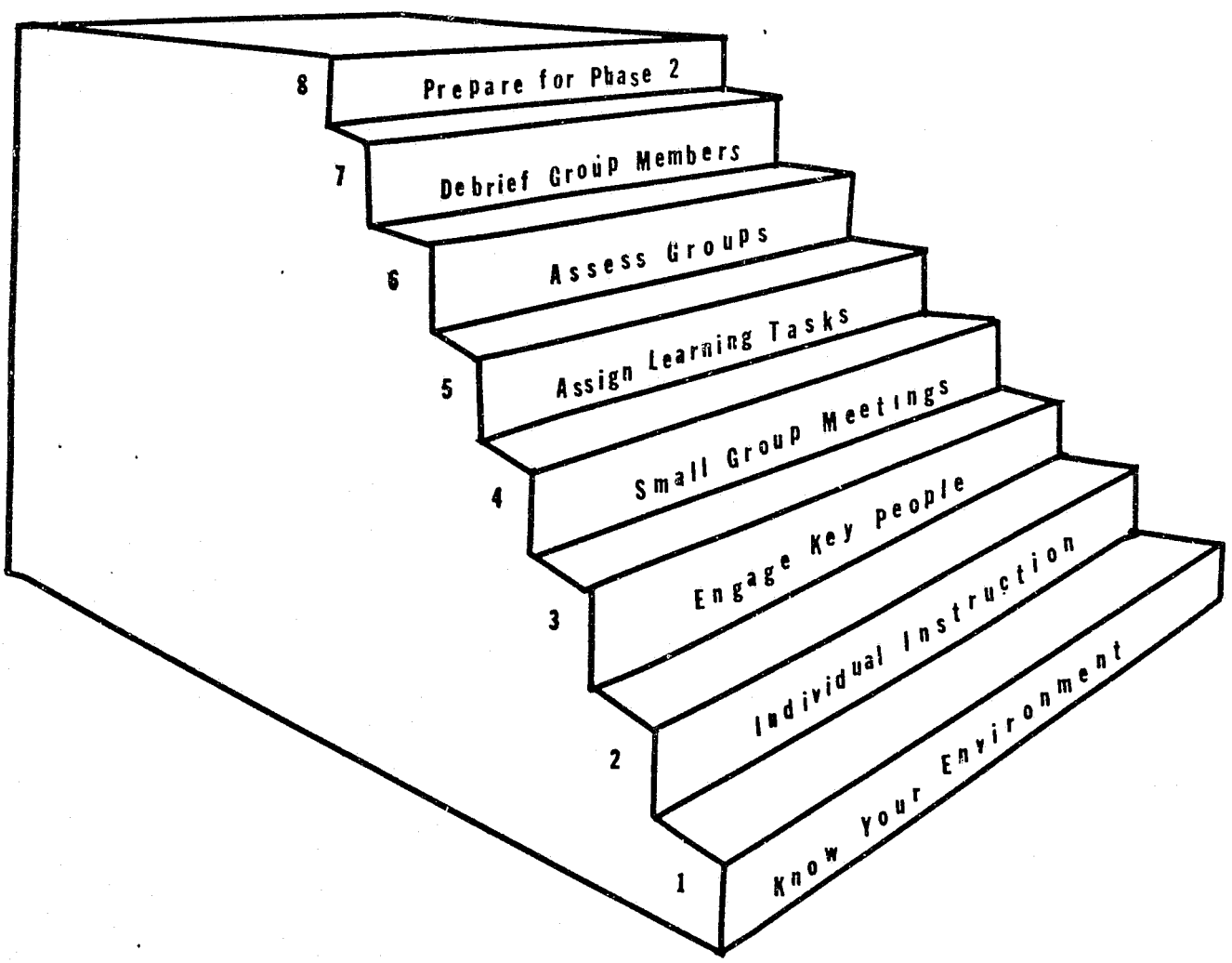
The model is in three phases embracing twenty separate but related steps.

Phase I deals with establishing an operating base,

Phase II is concerned with teaching the POMR Methodology, and

Phase III addresses the processes of Implementation and Evaluation.

PHASE 1



ESTABLISHING an OPERATING BASE

PHASE I ESTABLISHING AN OPERATING BASE

Chart I portrays eight distinct steps related to establishing an operating base for implementing the POMR system.

Step 1:

Step 1 is knowing your environment and establishing rapport with the people that you will be working with. You may already feel that you have good rapport with your peers on the job. However, you are now setting about to do something different; to have the other people in your work environment change their way of working together.

So you need to spend some time with each person, finding out what each likes about the present medical record system, and what seems not so good. It is a good idea to keep notes on what you are finding out at this time because you are beginning to model for the others the POMR approach. Your first step is one of developing a Data Base which in turn leads to a Problem List related to the present medical record system.

The person-to-person process that is occurring at this time serves to get each person involved in "doing something" about medical records, instead of resisting your efforts to change the present system.

Step 2:

"Doing something" leads to Step 2, which is beginning individual instruction about POMR. This is a very informal process in that you do not tell people, "Look, I'm going to teach you somethin." Rather, you demonstrate how in the records that they are using the technical process of S.O.A.P. ing can be carried out to advantage. That is, you take a problem that you or one of your peers is working and ask the simple questions necessary to develop a S.O.A.P.based Progress Note. That is, ask, "What does the patient say is the problem?" Then write the answers down. Next, ask "What have you observed from your clinical assessment?", and write those answers down. Now ask "What do those two sets of data tell you about the problem?" Write the answers down, then ask "Now what are you going to do about it?", and write that down.

Once your peers have gotten a feel for this approach, encourage them to use it whenever they have a special problem to work on. It may seem strange teaching the S.O.A.P.technique first, but the fact is that people are already using it and all you are doing is helping them to systematize the method.

Step 3:

While they are doing that you can go on to Step 3, which is to engage all of the key people in the environment in a process of working as a team to introduce the POMR system. These key people will include the head physician, the director of nurses, the chief pharmacist, etc. If you have carried out Steps 1 and 2 reasonably well, they will be aware that some changes are beginning to occur and will want to know more about it. So, spend some time with each of them, tell them how the system works, and enlist their approval and support for you to go ahead with the work of establishing an operating base.

Step 4:

You want their endorsement of the idea, and their approval of your involving staff members in small groups to begin working on Step 4, which is small group meetings.

The purpose of those meetings is to extend your instruction efforts through peer learning. That is, in the small groups you learn from each other but you, as the facilitator, must help the others by giving them some sense of direction. You do this by carefully directed questions aimed at drawing out their ideas about what constitutes the data for a prisoner medical data base, and what kinds of problems seem to be typical of your particular patient population. Remember, follow the earlier procedure of asking the question, then writing down the answers. For example, you might ask the small group members, "What data do we need to have about our patients in order to make a quality assessment of their condition?" You will quickly generate a rich array of things. Then you may want to go over the list together to see if some things cluster together. As you begin to collect these ideas, you might also be asking, "What kinds of problems do these data point to?" (Not diagnostic nomenclature but behaviorally defined problems.)

Step 5:

You are beginning to get the small group members involved in developing their own POMR system, and thus far you haven't even mentioned POMR to them. But about this time you should move to Step 5, which is assigning learning tasks.

At this stage, the learning tasks are still related to Data Base and Problem List activities. For instance, you might ask the group to see if they could devise a simple form for collecting the data about patients, or you might ask them to develop a typical list of problems encountered on sick call. The important thing is that your peers should begin to put some of these ideas into practice in a way that will work in your setting and with your unique group of patients.

By the end of this step you should have the nucleus of a POMR format, in that you have developed sample forms for a Data Base, a Sample Initial Problem List, and a method of reporting progress in problem management, i.e., S.O.A.P.ing. All that remains is to fit in the fourth element, namely the treatment plan. While the responsibility for starting this lies with the physician, it is a team reponsibility to see that the physician has the data and knows what problems have been identified.

Step 6:

Step 6 then is to review and assess the small group meetings with the key personnel such as the chief physician and director of nurses and to discuss the progress of each individual in moving toward a clear awareness of the value of the POMR approach.

Your purpose here is to obtain the sanction of these team leaders to proceed with the next steps prior to moving to Phase II.

Step 7:

Step 7 involves de-briefing the members of the small groups about what you have been doing. This can be done by reviewing quickly the preceding six steps with them, then leading them in discussion about the problems they have encountered thus far. De-briefing questions should be designed to stimulate thoughtful discussion. For example, "Do you think a prison Problem List ought to be different than one for an acute care hospital?", or "Would a Data Base need to be different than the information found on the main prison record?"

Step 8:

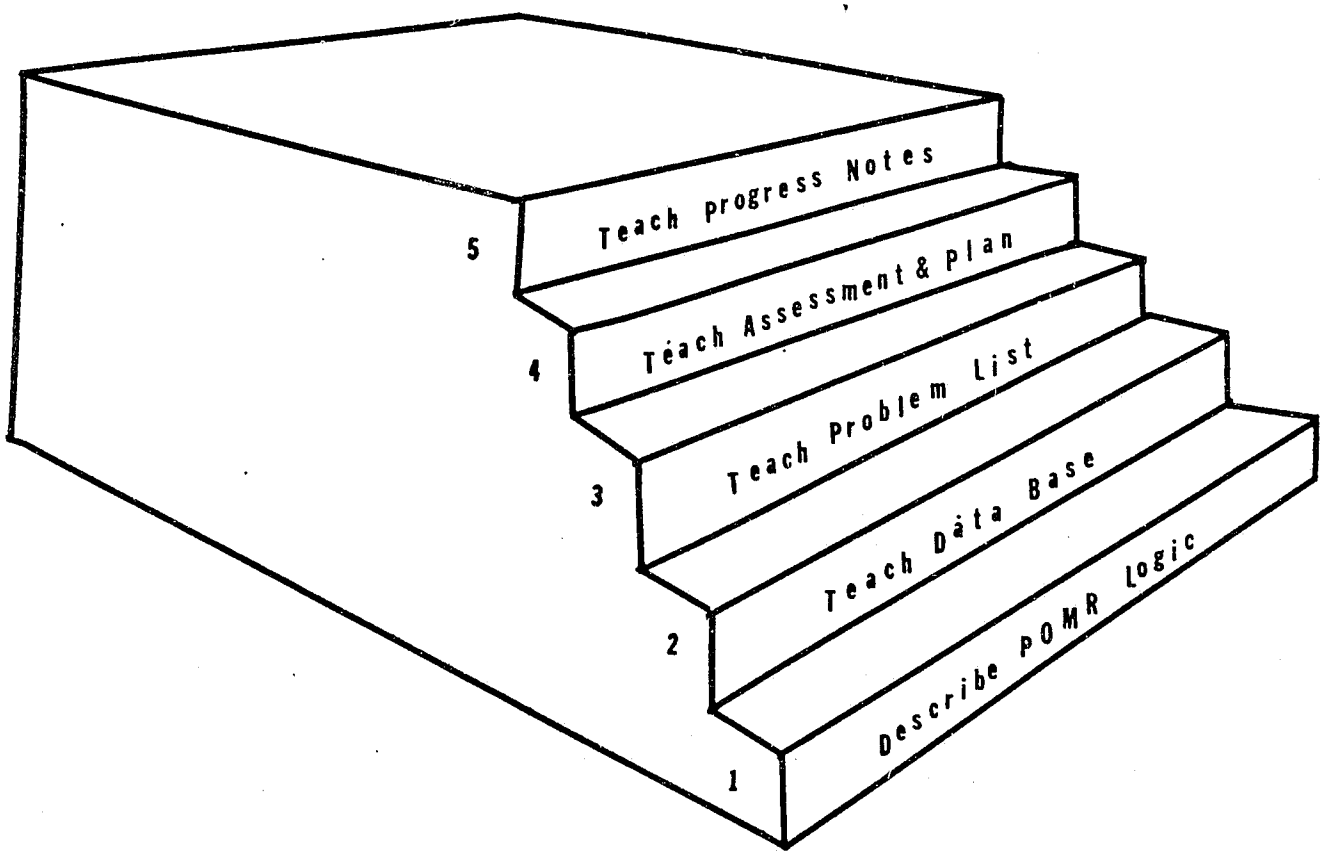
Allow enough time in this de-briefing period so that all concerns can be aired - Write down the concerns that you hear - Then go to Step 8, which is to prepare the group for Phase II.

In this step you will outline for them how you propose to instruct them in the technical process of POMR, and what your expectations for that instructional period will be.

Note: You may feel comfortable enough to handle Phase II yourself, or you may wish to call upon some technical assistance from people who are experts in both POMR and didactic instruction.

If you have done a careful job of carrying out Phase I, your peers should now be pressing you to move on to Phase II.

PHASE 2



TEACHING THE POMR METHODOLOGY

PHASE II TEACHING THE POMR METHODOLOGY

The style of teaching that you will use will depend greatly on your own perception of how cognitive learning occurs, how you communicate with others, and how your students learn. Generally, adults learn differently than children so that the usual classroom approach of teacher up front and students "all-in-a-row" doesn't work too well.

Adults already know a great deal so you have to ascertain what about your subject they already know, then build from that. If some of the things they know are incorrect you will need to deal with those misperceptions, but try, as much as possible, to work from what they do know that is right.

Step 1:

Step 1 in the educational process in POMR is describing the logic and rationale of any medical record system. That is, POMR is only one way of keeping medical records, but it is a carefully thought-out method that has an internal logic, a highly rational approach, and a systematic step-by-step set of procedures that facilitate communication and good patient care.

The logic of the system, for example, lies in the fact that it collects observable data about the patient in an orderly way that is unique to your setting.

It is rational in that it follows a disciplined approach that is in keeping with the disciplined methodology of health care professionals in general.

In carrying out this step then, use examples from practice to demonstrate that medical record keeping serves a variety of logical, rational purposes ranging from dealing with a patient's complaints, to aggregating data about several patients, to assuring both clinical and legal protection of patients, staff, and the institution.

The purpose of this step is to quickly build a base upon which to erect the POMR model.

Step 2: Step 2 is teaching about the Data Base.

Your group has already been doing some work with Data Base materials, so now your task is to build on that by showing them how the Data Base derives from their team efforts at gathering relevant information about the patient and the patient's condition. The Data Base is something that most health professionals have been using during their entire professional practice, so it should not be new to them.

What you will be doing is helping them to relate this material to a somewhat different system than they formerly followed. That means that you will need to get them thinking about how to collect data not with a view to jumping to a diagnosis, but rather with a view to translating those data into clear problem statements that the treatment team will be working on.

Use the examples in this manual in Chapter 2 to help your group get a grasp of the Data Base concept.

Step 3:

Then move on to Step 3 which is the Problem List.

Examples from your own setting will be very helpful here. Your goal is to begin to engage your group in a "hands-on" process now that you have some data to work with.

Give the group a brief informational talk about the reason for a Problem List, how it is set up, who enters problems on it, how it is displayed in the chart.

Then have them take the data on one or two cases and develop a Problem List of their own. You may want to separate the group into sub-groups for this part of the training, but have each sub-group report back to the full group as you proceed.

You may also want to give individuals some "chart-station" assignments, particularly if you are doing the training over a period of several days. Have them select a patient record (perhaps a new admission), build a Data Base, and a Problem List. If you decide on this approach, it's a good idea to monitor what is being done by making periodic checks of the record and discuss the notes with the individuals involved.

Remember, you are learning together, so if you don't agree do not correct. Ask why such and such a procedure was followed. That way the other person has a chance to develop a rationale for the approach used, and to modify it if the solutions seem unworkable.

Students need lots of practice with the Problem List, and beginners need lots of help. Bring in the technical assistants if they are available at this point--their experience can help all of you develop the best format for your institution.

Step 4:

Once you have the idea of the Problem List well in hand, move on to Step 4, the assessment and plan.

As you have learned from the earlier instruction part of this manual, each problem requires an assessment and plan to resolve the problem. Again, you should spend some time discussing the rationale for this step, then get people involved in writing plans. Even though the ultimate responsibility for each plan lies with the physician, other personnel may well participate in the process of writing Initial Plans that are reviewed and if acceptable signed off by the physician.

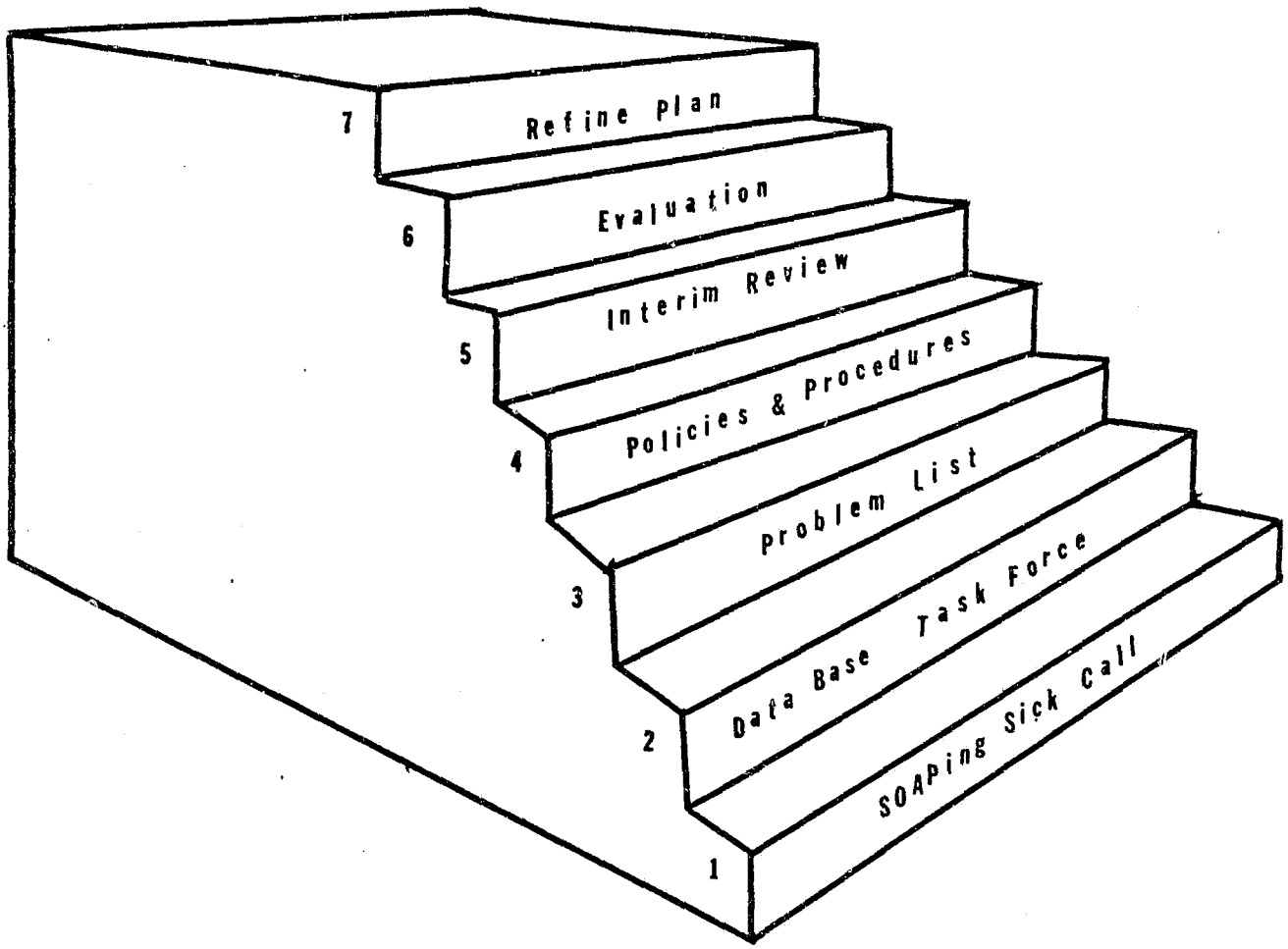
Step 5:

Once the plan is understood, there is a need to account for the results of actions taken on the basis of the plan. This leads you to Step 5, the Progress Notes.

In this step you will be returning to the beginning phase of your work with the group. You will be teaching them the S.O.A.P. process as a means of recording progress on a problem-by-problem basis. S.O.A.P.ing is a learned skill, not one that we inherit. Therefore, go back to the "hands-on" approach. Use the "chart-station" approach or the exercises in this manual, but get the group members to practice the skill, and monitor what they are doing.

When you have completed this step you are now ready for the big league, where you actually implement the POMR program.

PHASE 3



IMPLEMENTATION and EVALUATION

PHASE III IMPLEMENTATION AND EVALUATION

Before moving ahead with Phase III, be sure you still have the key staff with you. You should have been keeping them informed as you progressed through Phase II, and ideally they should have been involved in the training. If not, be sure to inform them of what you are doing at each step.

If you are encountering resistance from the key personnel, call on the technical assistance available through various outside consultants. Sometimes it is easier to work from outside than from inside when trying to bring about change.

Step 1:

Step 1 in Phase III is introducing the S.O.A.P. procedure to the sick call.

Have all professional staff begin to do a subjective and objective appraisal of the patient, recording the results on the sick call chart. Then have them assess these data and develop a plan, both of which are also written on the chart.

Do this only for new problems on sick call, and very quickly you will find that you have POMR type Progress Notes showing up on most of your records.

Once this pattern is established, move on to formalizing the POMR in the following way:

Step 2:

Develop a Task Force to create Data Base forms that will meet your institution's needs. This Data Base needs to be the product of the team, not just of one person so have some cross representation on the Task Force.

Step 3:

When the Task Force is satisfied with the Data Base, have them catalogue a Problem List that identifies most of the main problems your institution encounters. The advantage of this is that it standardizes problem statements so that all team members are using the same definitions

for the main problems, thus following up with standard plans that all team members understand. It will also be possible to code your problems so that they may be indexed and retrieved for retrospective evaluation of the care you are providing.

Step 4:

Developing written policies and procedures. Once you have the Data Base forms and a workable Problem List your next step is to have the entire group or a Task Force begin writing policies and procedures for using the POMR procedure. This is a highly technical process, so again you may want to call upon technical assistance from other POMR specialists.

Step 5:

Step 5 is an interim review step in which a Task Force reviews selected records to see how well the implementation process is going. If changes are needed they can be introduced at this point and a further "dry run" can be taken with a second Task Force review. Some of the questions the Task Force might ask are: Is there a Problem List on every record? Is every sick call encounter S.O.A.P.ed? Which practitioners appear to understand the S.O.A.P.ing procedure, which do not? Is there a current Data Base (history, physical, lab result) on inpatients having surgery?

Step 6:

Step 6 is the evaluation step in which all forms are reviewed for completeness by using criteria developed by medical and nursing staff and a technical assistant. Evaluation questions may now focus on both the POMR system implementation and the quality of the POMR documentation; e.g., is the resident's medical record being pulled and used for every patient encounter, is the information on the S.O.A.P. really meaningful, does it really state what the problem is, if problems are picked up on a flow sheet, are they flagged and S.O.A.P.ed in the Progress Notes.

Step 7:

Finally, in Step 7 the Plan is refined according to the findings of the evaluation and forms, and policies and procedures are introduced as the standard for POMR in your institution.

This step-by-step guide may seem overly solicitous because of its seeming simplicity. In fact, if you follow the steps you will find that you have engaged in a very complex, technical and interpersonal management experience, called Organizational Development. Because of that a final word of caution is offered. POMR is not built in a day. Give yourself plenty of time on each step. Anticipate resistances. Anticipate your own impatience. Remember that prisons move slowly and so will your project, but if you take each step carefully, involving all the key people at every step, you will come out with a program that will be of tremendous worth to your patient's well-being, your own peace of mind, and to the institution's capability to do its job.

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**Mazur, W.P., The Problem-Oriented System in the Psychiatric Hospital: A Manual for Mental Health Professionals, Trainex Corp., Garden Grove, California.

*These are self-instruction handbooks which serve as an excellent guide in learning the technical aspect of POMR. $7.50 for each of the above.

**This is a 90-page manual that presents the information necessary to adopt the POMR in the psychiatric setting. It is based on the author's work in establishing POMR in a state hospital. It provides a step-by-step chronological guide for implementation in a psychiatric hospital.

RESOURCES

Audiovisual Aids

1. Films

"Problem Oriented Medical Record" by Lawrence Weed, M.D.
Case Western Reserve University, Health Center Library,
2119 Abington Road, Cleveland, Ohio 44106.
$15.00 rental. 20 min., B & W, sound, 16 mm.

Film illustrates the component parts of a problem-oriented record and how to create it.

2. Cassette Tape

"The Problem-Oriented Record: Lawrence L. Weed in Atlanta,"
56 minute tape, $6.00, Listener's Guides (10¢ a copy),
Medical Computer Services Association, 100 U-District Bldg.,
1107 N.E. 45th Street, Seattle, Washington 98105.

Dr. Weed discusses the need for the problem-oriented system and then elaborates on the phases of the system.

3. Videotape

"Special Workshop on the Problem-Oriented Medical Record,"
Network for Continuing Medical Education, 15 Columbus Circle,
New York, N.Y. 10023, 50 minute tape. Free to members of Network.

An introductory workshop on the POMR which provides active participation in the examination of 2 patients. Program presents good forms.

4. Slide/Sound Program

"An Introduction to Problem-Oriented Medical Records for Nurses." **
"An Introduction to Problem-Oriented Medical Records for Practitioners." **
-Sixty-four 35 mm. color slides
-Tape Cassette
-25 sets of simulated patient records for handout
-Script of presentation

Provides an overview of the logic and structure of POMR. Uses an acute patient situation for comparing source oriented and problem oriented recording. Assesses advantages and limitations of POMR. Programmed to stop for questions, discussion. Charge is $50.00 each for purchase. $10.00 each for 10 day rental.

5. Instructor's Manual for Teaching POMR to Nurses. Instructor's Manual for Teaching POMR to Practitioners.**

Provides a complete program for introducing and teaching each component of POMR. The six 1 1/2 hour sessions include:
- Learner objectives
- Teaching outline and special materials
- 24 (35 mm. color slides) and perforated handouts for distribution
- Teaching tips emphasizing critical points
- Bibliography

Manual comes with a copy of FORMAT AND FORMS, 41 pages providing instruction and guidelines for recording and form design. Charge $45.00

**Audio-visual aids listed under #4 and #5 can be obtained through:

POMR Project
Michael Reese Hospital and Medical Center
530 E. 31st Street
Chicago, Illinois 60616