PROBLEM ORIENTATED MEDICAL RECORDS (POMR)

GUIDELINES FOR THERAPISTS

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Further copies of these guidelines can be obtained from the:

King's Fund Centre, 126 Albert Street, London NW1 7NF

ACKNOWLEDGEMENTS

Diane Kirk, Ann Parsons, Margaret Scholey and Louise Wakeling prepared this booklet for the Documentation and Retrieval Group, Special Interest Group of the Chartered Society of Physiotherapy (CSP). Ida Bromley and Marilyn Harrison were very supportive and the King's Fund Centre published and distributed the booklet.

FOREWORD

The current emphasis on **quality assurance** is highlighting the need to audit clinical practice in all branches of medicine. To undertake this task requires adequate, legible records which contain the relevant data.

This booklet has been produced in response to the demand for information on the record keeping section of the **Problem Orientated Medical System** and deals *only* with the **Problem Orientated Medical Record.**

The information has been kept brief for easy reference, the style is simple and examples are included. Physiotherapists and those from other medical disciplines who wish to accept the challenge of transferring to this system of record keeping will find this a useful tool for effecting the change.

May 1988

INTRODUCTION and ADVANTAGES

The Problem Orientated Medical System (POMS) originated in the USA where Lawrence Weed MD began developing it in 1956.

There are three main components of the system:

- Problem Orientated Medical Recording
- Audit
- Education Programme

Problem Orientated Medical Recording (POMR), is a systematic way of writing a record of the patients' progress through a course of treatment. There are four sections to POMR:

a. Database
b. Problem List
c. Plans
d. Progress Notes and Discharge Summary

It was originally designed for the multi-disciplinary approach. Each member of the team examines and assesses the patient, then meets to work out a list of the patient's problems and to formulate plans together. Each member of the team adds their progress notes related to the problems they are working on. It is suitable for use in a unidisciplinary department.

The advantages of POMR

POMR is designed to keep all the problems, plans and follow-up notes clearly in view.

The main advantages of using this System are:

1. It encourages **LOGICAL** thinking by:

   - directing the therapist to the patient problems, not the diagnosis.
   - making the major problems easily identifiable.
   - prompting the therapist to modify treatment as the problems change.
   - preparing for the computerisation of patient records.

2. It encourages **EVALUATION** by:

   - allowing easy access to information, so that problems for review can be easily followed.
   - providing adequate information for peer review and continuing education.

3. It is valuable in **LEGAL** cases because it:

   - encourages staff to document accurately and in full.
   - allows patient's problems to be monitored carefully.
   - encourages the therapist to state their professional opinion, based on subjective and objective findings.

The correct stationery facilitates this type of recording system, Separate sheets for each section, e.g. database, problem list and progress notes will make it easier to follow the system through. See *Appendix 1* for one method of documentation. Other methods may be equally acceptable.

DATABASE

The database consists of all the information that has been gathered about the patient. It includes the following:

Personal details
Name, age, address and referring doctor.

Referral details
Diagnosis and contra-indications.

Medical history
Past and Present.

Pertinent social factors

Physiotherapy examination and assessment
Subjective and objective data.

Additional Information

This information can be collected from any relevant source, e.g. Consultant, Occupational Therapist, including X-ray findings and laboratory tests.

It may be recorded on a database form or on a specialised assessment form depending on local requirements.

From the database and discussion with the patient, a list of problems is formulated which will be entered on the problem list page.

These need not be in order of severity or priority. The list can be added to as more problems are identified.

THE PROBLEM LIST

A problem list is compiled after examination and assessment of the patient, it is a concise list of the patient's actual problems at that time. It should be the first page of the patient's record for easy reference, and set out in columns.

Date	No	Active	Inactive	Signature
20.6.86	1	Limited range of movement of knee due to effusion.		L. Wright
20.6.86	2	Painful (R) wrist 2/12	30.6.86	L. Wright
20.6.86	3	Limited independence a. Poor vision b. Poor balance		L. Wright
1.7.86	4	Unsuitable housing	Rehoused 1.7.87	L. Wright

Figure 1

Date

The date of the initial problem list is the date of the assessment. If the length of time that the patient has had the problem is relevant, it may be noted e.g. left shoulder pain for three months. This is to allow easy reference since the details can be found in the assessment or progress notes, under the date given. Subsequent problems are added and dated as they are identified.

Problem Number

Each problem is given a number and this number stays with the problem throughout the patient's course of treatment The number is used to identify the problem all the way through the progress notes and facilitates following a course of treatment. Occasionally reassessment leads to a change of emphasis of a problem, a new number is given to each new problem added. Associated problems may be grouped together on the problem list.

Active and Inactive Columns

Problems should be listed in the active column i.e. they are problems *now* not potential problems or past problems Where the management of the patient is to prevent problems occuring, they should be identified. One way of doing this is illustrated in *Figure 2* where the risks can be identified by a professional therapist.

Date	No	Active	Inactive	Signature
01.10.87	1	Confined to bed	18.10.87 mobilizing	
14.10.87	2	Painful knee	22.10.87	

Figure 2

The problems should be listed as concisely as possible and should be a factual statement of all the patient's problems, i.e

physical; medical; psychological; social

although not all patients will have problems under each of these headings.

As treatment progresses, problems may become inactive and this change of status should be recorded by an arrow and the date in the inactive column, as illustrated. Alternatively the inactive column could be headed **Resolved** and this enables physiotherapists to note the means of resolving the problem.

The problem list is the key to POMR. It should be simple, functional and specific. Time spent preparing the problem list will facilitate effective and efficient patient care (*see De Weerdt and Harrison 1985*).

INITIAL PLANS

The first stage of writing the plans is to formulate long and short term objectives or goals for each problem. Whenever possible the patient and/or the carer is included in these decisions. (An objective states who will do what, when and how.)

For example, for a paraplegic patient in a wheelchair,

Long term objective

Mr X will take care of his own pressure areas by the time he goes home (date).

This may be reached in several stages and short term objectives written for each stage. For example:

Short term objective

Mr X will lift himself to relieve pressure every ten minutes without being reminded, by the end of the week (date).

The objectives are evaluated and reviewed on the target date.

Subsequent short term objectives should be added as necessary in the progress notes. Initial plans should include modalities and frequency of treatment and the patient education. In some instances, the plans may relate to more than one problem, e.g.

PROBLEM (Mrs Y)

1. Painful neck.
2. Pins and needles, left arm.

Initial Plans for Problems 1 and 2

Long term objective

Mrs Y will be able to return to full time employment after six treatment sessions and will be able to manage pain; no sensory changes.

Short term objectives

Relief of some pain and sensory changes by the end of the second treatment session.

Plan 1 and 2

Daily cervical traction and advice on sleeping position.

As treatment proceeds, changes of plan are noted in the progress notes.

PROGRESS NOTES

In the POMR format, progress notes are usually referred to as **SOAP** notes. These can be supplemented by flow charts and graphical illustrations.

The letters stand for:

S	- Subjective	what the patient says, what the doctor or nurse reports, or what anyone has commented about the patient.
O	- Objective	measurements that can be repeated or reproduced by another therapist such as an increase in flexion 90 degrees, or distance walked.
A	- Analysis	the physiotherapists' professional opinion based on the above findings.
P	- The Plan for the Future	e.g. see twice only next week and/or the treatment carried out that day.

The progress notes are usually written on paper with three columns on the left hand side *(Appendix 1)*. The first column is for the date of the entry, the second denotes the number of the problem to which the entry refers. The third column is for one or more of the S.O.A.P.headings. It is only necessary to record relevant S.O.A.P.notes - not e.g. all four and they can be in any order. For example, patient Mrs Y *(page 8)*

12.8.86	1	S	Slept better last night
	1	P	Relaxation exercises taught, will check tomorrow. J.Smith

Note: Cervical traction was the initial plan; it has not changed therefore, it is not mentioned.

Entries need only be made when there is a change in either the patient's condition or their treatment. Phrases such as *ISQ* or *as above* are never used. Notes are sometimes used to record attendance in which case the date and physiotherapist's initials can be entered. The actual treatment given may be recorded under P. In acute conditions where changes occur quickly, it is usual to note something at each face to face contact. Flow charts are useful to record treatments such as UVL, traction or other electrical treatment where daily record of method, dosage and equipment used are essential for legal purposes *(see Appendix 2)*. Graphs are also invaluable for illustrating changes in joint range, muscle strength and pain.

THE SUMMARY

The summary is a very important part of POMR as it is the conclusion to a course of treatment. It is useful in providing a resume of treatment and facilitates retrospective studies, audits and research. If a patient is referred, the previous treatment and the results of that treatment are readily available.

The summary can take the form of a :

Transfer summary When a patient is transferred to another department or hospital.

Discharge summary When the treatment is discontinued or the patient dies.

The content of the summary, depending on local requirements may include any of the following information:

1. Outcome of treatment related to numbered problems.
2. Aids/appliances that have been ordered or supplied.
3. Other agencies involved e.g. social worker; speech therapy; occupational therapy.
4. Any instructions of home programme given to the patient, relative or carers.
5. Any other departmental requirements.

Implementation

When the decision has been made to introduce the system, it is recommended that help should be sought from a therapist experienced in using POMR. Training for all staff before implementation is desirable. Contact names and addresses can be obtained from the D. & R. Group Secretary, c/o C.S.P.

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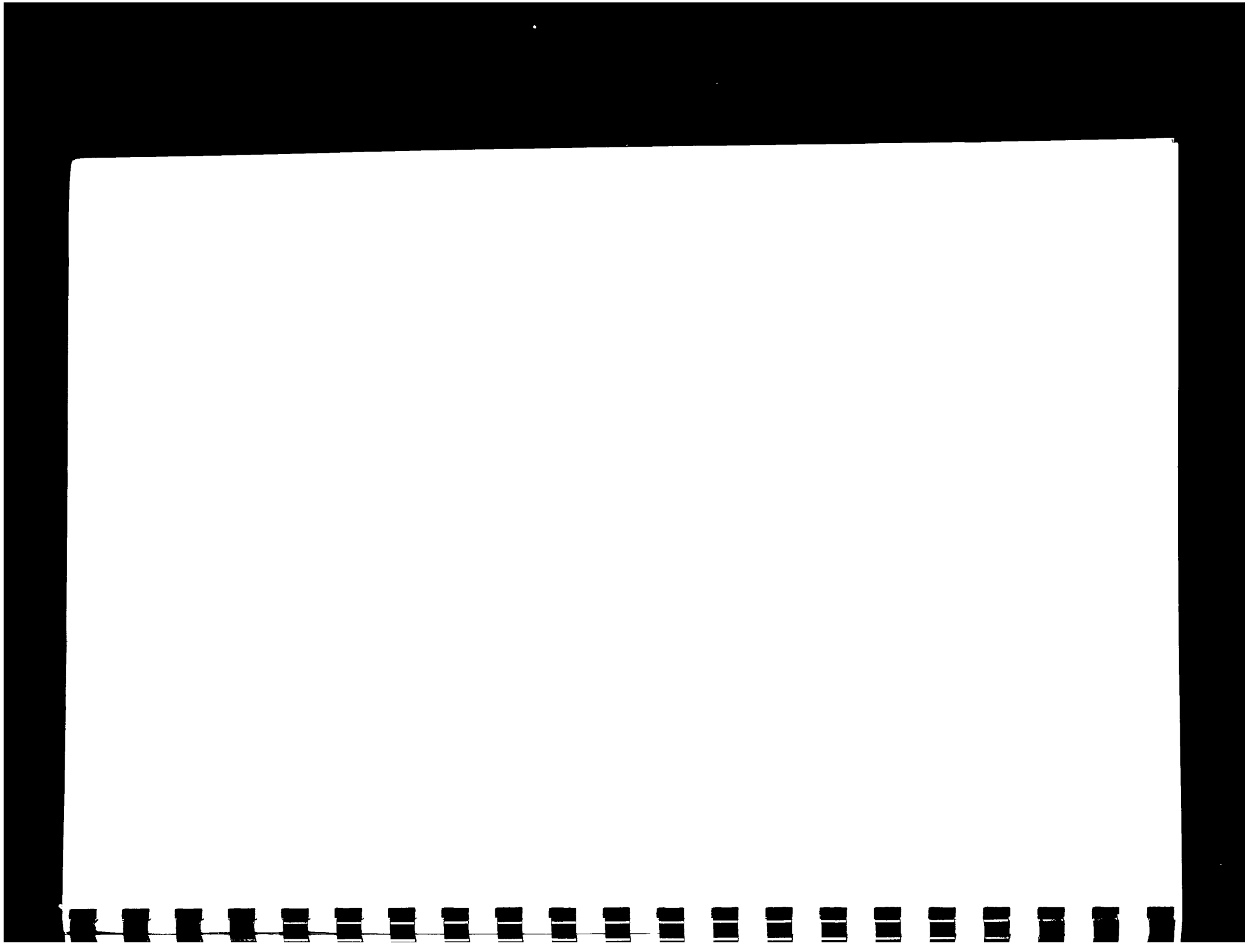
A P P E N D I X 1

Examples of Documentation



.....DISTRICT PHYSIOTHERAPY SERVICE

Address/Ward..... Hospital No..... G.P.No.....

.....

..... Surname.....M/F

Telephone:Home..... Work..... First Name.....M/S/W

Date of Birth..... Age..... Consultant..... Review Date.....

Occupation..... G.P..... Transport Y/N.....

Diagnosis.....

.....

.....

.....

.....

Signature..... Date.....

PROBLEM LIST

Date	No	Problem	Inactive/Resolved	Signature

.....DISTRICT PHYSIOTHERAPY SERVICE

Continuation Sheet

Record No:.....

Surname:.....

First Name:.....

Date	Problem No.	SOAP		Signature

A P P E N D I X 2

Examples of Flow Charts

.....HEALTH AUTHORITY PHYSIOTHERAPY ULTRA-VIOLET LIGHT RECORD CARD

Name..... Record No..... Please tick:

Diagnosis..... Consultant.....

Contraindication checked ☐
Test dose ☐
Warnings given ☐

Area to be treated..... C O M M E N T S

Date	Lamp used and I.D.No.	Patients Position	Area Exposed	Distance	Time	S	O	A	P	Signature

PHYSIOTHERAPY SERVICES

Patient Treatment Record for all Electrotherapy and Traction

Name..... Record Number..... Area treated.....

Address..... Consultant..... .....

..... Diagnosis..... Please tick box:

Warning given re. burns ☐

D.O.B./Age..... ..... Skin sensation ☐

Test dose ☐

Date	Machine (± I.D.)	Patient Position	Method ± electrode size	Dose	Time	Comments	Signature