California State University, Northridge

PROBLEM-ORIENTED MEDICAL RECORDS--A MANAGEMENT TOOL

FOR A SKILLED NURSING FACILITY

A graduate project submitted in partial satisfaction of the requirements for the degree of Master of Science in Health Science

by

C. Arthur Wardner

June, 1974
The graduate project of C. Arthur Wardner is approved:

California State University, Northridge
June, 1974
I am greatly indebted to Dr. G. B. Krishnamurty, whose assistance, guidance and encouragement made this graduate project possible. To my advisor, Dr. Donald M. Huffman, my sincere appreciation for his suggestions and constructive criticism. A special note of appreciation to my wife, Helen, whose encouraging assistance was immeasurable during the final phase of this graduate project.
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ABSTRACT

PROBLEM-ORIENTED MEDICAL RECORD -- A MANAGEMENT TOOL
FOR A SKILLED NURSING FACILITY

by
C. Arthur Wardner
Master of Science in Health Science

The purpose of this study is to extend the Problem-Oriented Medical Record system, originated by Dr. Lawrence L. Weed, by modifying this method for implementation in a 99-bed skilled nursing facility specializing in long-term, chronically-ill patients.

This project investigated the development and feasibility of implementation of the system in three phases:
1. The Problem-Oriented Medical Record System Modification.
2. An Analysis of the Facilitators and Inhibitors.
3. A Plan for the Implementation of the Problem-Oriented Medical Record System.

The material presented in this study consists of a synthesis of available materials written by practitioners utilizing the Problem-Oriented Medical Record system (POMR), interview evaluations of feasibility for implementation with other skilled nursing hospital administrators, and, thirdly, personal observation followed by logical conclusions.
Definition of Terms

**Skilled Nursing Facility (SNF):** Hospitals designed to care for the elderly or long-term patient, rendering 24-hour skilled nursing care.

**Chronic Illness:** Degenerative diseases associated with aging and long-term confinement.

**Acute Illness:** Brief and short-term diseases associated with crisis-oriented measures.

**Custodial Care:** Assisting the patient in the routines of daily living. No skilled nursing care involved.

**Program Evaluation and Review Technique (PERT or PERT CHART):** Network analysis providing a means of outlining the activities that must be undertaken and of identifying those events that must occur before a specific objective can be met.
CHAPTER I
INTRODUCTION

The medical record of the patient with a long-term illness can grow into a vast accumulation of data that could overwhelm and discourage any physician scheduled to examine him for the first time. Although many factors can be involved in producing the reticency a physician may feel for the patient who is chronically ill, the most common of these is the prospect of culling pertinent information from the massive amount of detail in the medical record. (1:275)

As more and more people become involved in the care of a given patient, it becomes increasingly difficult to discuss the patient's problems on a one-to-one basis.

Two fundamental steps in working more effectively are: establishing a practical system of communications for use in caring for the patient, and setting standards for such a system so that problems and progress can be defined.

Central in the present system of communications is the medical record, upon which patient care, much clinical investigation, and medical education depend. In its current state it is an instrument full of serious faults, being sometimes irregular, diffuse, subjective and incomplete. Developed standards for the preparation of the medical record do not exist. There is in existence at the present
time only a limited amount of literature on how to structure the medical record, particularly progress notes on long-term problems. Consequently, there does not exist a framework within which medical record standards can develop. (28:7-8)

This project proposes a solution to this situation with the implementation of a Problem-Oriented Medical Record system. The medical record need not be simply a static repository of medical observations and activities grouped in a meaningless order source; it can be problem-oriented and thereby become a dynamic, structured framework for facilitating comprehensive care. But in addition to being problem-oriented, the medical record must be concise, and complete. The medical record must serve the experienced physician and yet be intelligible to the nurses aide; it must give freedom of expression to the most perceptive, yet must establish form and order to prevent personalization. The record must serve the patient as well as the physician. A good medical record must require that complete discipline, logic and integrity be exercised. These are methods which convert repetition into experience and wisdom. (28:8)

Dr. Lawrence L. Weed's premise is that education should not be a memory-dependent system (core of knowledge), but that education should provide a core of behavior so the individual will become thorough, reliable, analytically sound and efficient, capable of learning and thinking on his own. (28:8)

Dr. Weed's system is rapidly becoming widely known and
accepted in clinical medicine. (8:488) Its significant advantages, innovations and methods of maintaining medical records have demonstrated a very definite need for a well designed and easily understood system which would train physicians, professional staff nurses, nurses aides and other paramedical personnel to write realistic and workable plans, suitable to all types of health facilities and specialties. (21:7)

Medicine has been traditionally geared to respond to the acute illness. Today the chronic illness plays a much greater role (12:13), consequently the impetus for change in medical recordkeeping in the skilled nursing facility (SNF) comes from the recognition that our current recording system does not adequately fulfill its desired objectives.

In the development and plan for implementation of a Problem-Oriented Medical Record system for a SNF, a three-phase approach is considered:

1. The POMR System Modification, modified and designed for utilization in a SNF.

2. An Analysis of the Facilitators and Inhibitors in the Implementation of the System.

3. A Plan for the Implementation of the POMR System (Program Evaluation and Review Technique) PERT CHART. A network analysis will provide a means of outlining those necessary activities that must be identified and undertaken to insure that they occur before a specific objective can be met.
Statement of the Purpose

The genesis of this study occurred when the author first became aware of the Problem-Oriented Medical Record system and its accelerated use by physicians in private practice and general acute hospital recordkeeping. (11:254) (21:7) The purpose of this study is to deal with a plan for the implementation of a modified POMR system within a skilled nursing facility while overcoming existing resistance to change, through the introduction of a "planned innovation process."

Limitations of the Study

This study was limited by the fact that POMR systems have been a recent development. Little, if any, comparative information was available to the researcher. The plan developed for this study has not been implemented, therefore data were not available for comparative purposes to evaluate the quality and effectiveness of medical care in contrast to a facility with standard records.
CHAPTER II
LITERATURE REVIEW

Origin of the Problem-Oriented Medical Record System

For more than 16 years, Dr. Weed has endeavored on changing the structure of the medical record to an established scientific document worthy of medical discipline. Obviously, this is far more than a new recordkeeping system. This is an entirely new concept in the teaching of medicine, the way physicians approach the care of their patients and the manner in which medical audits are conducted. (31:32)

Generated by Dr. Weed's system, this fundamental reconstruction in data keeping has gained enthusiastic and vocal advocates, two of those being Dr. Harold D. Cross and Dr. John C. Bjorn, who now utilize this problem-oriented system in their two-man general practice. (31:34)

Since 1969, when Dr. Weed first published his book "Medical Records, Medical Education and Patient Care," there has been a definite revolution in medical recordkeeping, a movement that could profoundly change the practice and philosophy of medicine.

Dr. Weed, a professor at the University of Vermont School of Medicine, has received favorable widespread atten-
tion and, judging from the increased use, the Problem-Oriented Medical Record system may lead to a nationwide format for a universal health record. (3:31-32)

Meanwhile, the POMR has been instituted in private practice, hospitals of all sizes, and a few medical schools.

A recent survey of selected general hospitals in 25 states by the American Medical Record Association (1973) indicated that 43 percent of California's surveyed general hospitals were now using the Weed method to some degree. Almost half of the hospitals not using POMR reported that they had made definite arrangements for its later use, while a quarter of that same group had no plans to implement the system. (21:6-13)

Components of the POMR System

Essentially, the problem-oriented approach requires the physician or the nurse to identify, list and number all of the patient's problems, psychiatric, social, and demographic, as well as past and current physical complaints. All subsequent data, including the plans, orders, progress notes and discharge summary, are cross-indexed to the numbered problems, resulting in a correlation of physicians' orders with problems. The list is then modified as problems are clarified, altered or diagnosed; those which are resolved or dropped are marked accordingly. (3:32)

The POMR system has four elements: data base, problem list, problem assessment and plan formulation, and progress notes and related data. (21:8) The first step in the
system is establishing a data base.

The data base consists of essentially the same information found in the traditional admission workup -- initial history, physical exam, and laboratory tests. However, with the Problem-Oriented Medical Record system, the information is standardized, which means that those concerned with the delivery of health care to a given population have defined the content of the data base prior to instituting the use of the POMR system. The specific information to be included is that which those practitioners believe to be necessary if they are to provide efficient, economical, comprehensive health care to long-term, chronically-ill patients. (23:511)

To insure uniformity and standardization of the data base, this information must be obtained from every patient who receives service. Properly developed, the system defines clearly what data must be collected in a consistent manner for each patient. The following items have been expanded and modified from Weed's POMR system, for a population group of long-term patients in a skilled nursing facility:

- **Chief Complaint**: The reason for the patient's visit.
- **Patient Profile**: A brief narrative about the patient and his way of life, providing a visual picture of the patient in his environment.
- **Psychological State**: General statement regarding patient's present adjustment, in-
Past History: Including significant related factors. Includes hospitalization and dates, operations and dates, past illnesses and/or serious injuries, medications for past conditions, smoking, drinking and allergies.

Family History: Ages and causes of death of parents, grandparents, siblings and children; history of congenital heart disease, diabetes, tuberculosis, rheumatic fever, high blood pressure, heart attacks, strokes, cancer and mental illness.

Present Illness: Brief narrative regarding present health problems, each discussed individually. Includes onset of the problem, progression, signs and symptoms, treatment and patient's understanding of the problem and its treatment.

Current Medications: Those prescribed and taken as directed, prescribed and not taken as directed. Self-administered, patient's knowledge of drug actions, dosage, side effects, and any other significant factors.

Diet History: Typical food consumption in a 24-
hour period, whether a prescribed diet or regular and the patient's understanding of the diet.

**Present Activity Level:**
Brief statement regarding how patient sees his present activity level in relation to past pattern of activity and future goals.

**Present Physical State:**
If patient has experienced any pattern or kind of change from normal.

**Physical Exam:**
Obvious physical defects not previously noted. Skin, lungs, heart, extremities, neurological evaluation, blood pressure, height and weight.

**Laboratory Data:**
Blood work, urine, x-ray, electrocardiogram, etc.

(Refer to Appendix, p. 54)

(15:28-50) (23:511)

In the second step the patient problems are identified on a problem list from the data base. The more adequate and appropriate the data base, the more comprehensive the identification of the problems. Problems are numbered, titled and listed as a dynamic table of contents in the front of the chart (refer to Appendix, p. 56). All of the patient's known physiological, psychological, demographic, and socio-economic problems are listed. (23:512)

The problem title is not documented as a specific
diagnosis unless it can be unquestionably confirmed by the data. Consequently, each problem is titled according to the level of understanding that is appropriate. Problem titles are changed as more information becomes available. Expressions such as "rule out," "probable," and "impressions" are not acceptable because they characterize patient care plans based on diagnostic hunches and are not included in the problem list. (23:512) (30:42)

The problem list is updated by any member of the patient care team as more information is documented, new problems are identified, active problems become inactive. The team members (patient, physician, nurse, activities director, physical therapist, social worker or dietitian) should communicate new information by making appropriate changes on the problem list. Maintaining a comprehensive problem list is a continuing responsibility of the patient care team with the patient being allowed to share in the responsibility, subject to the approval of the most senior physician responsible for the patient. (23:512) (30:50)

Physicians are required to review, under the requirements of Medicare, their patient's charts and progress of the patient every 30 days. (10:405,1035)

Third, an initial plan assessment is formulated for each problem that is individually described and evaluated. These and all subsequent data (orders, plans, progress notes, etc.) are recorded in the body of the record under the numbered and titled problem to which they are specific-
ally related (refer to Appendix, p. 57). Each active problem has its own plan. A plan has three components when applicable: (23:512)

1. Diagnostic studies.


3. Patient education. (This often neglected area includes such things as telling the patient how fast he or she may be expected to get well, symptoms that indicate a worsening of his disease, etc.)

Fourth, progress notes and related data made by members of the health care team other than the physician are not recorded as separate parts of the record. Nurses' notes, physical therapy notes, consultants' or other notations are recorded as progress notes and entered in a continuing sequence (refer to Appendix, p. 59). The series of progress notes related to specific patient problems and the format (SOAP) requiring explicit recording of data are two means by which the Problem-Oriented Medical Record system becomes a workable tool for improving communication among members of the patient care team.

**Subjective Data (S):** Subjective observations consist of symptoms reported by the patient with or without probing. Also, any gross observations about the patient.

**Objective Data (O):** Objective observations consist of vital signs, data from tests,
Assessment (A): The physician's interpretation of the current situation (related to the patient) in light of and with respect to the specific problem and original plans and objectives for that particular problem.

Plan (P): A plan of management in the progress notes contains the same elements as the initial plan. Each progress note is keyed to the problem with which it deals. (17:7)

Recording of data in this manner encourages the development and use of sound logic in problem analysis and plan formulation.

For more complex problems, flow sheets should be kept in addition to progress notes. This sheet is used to record specific parameters in a tabular or graphic manner. Monitoring various parameters is necessary for the proper management of complex problems. The patient care team develops a flow sheet to facilitate comprehension and interpretation of changing, interrelated variables. This sheet will assist the team in following the progress of such problems and may
be the only progress notes in the record for certain rapidly moving problems. (23:513)

**Evaluation of the Problem-Oriented Medical Record System**

The evaluation of the POMR system deals with the quality of the system itself. It takes into consideration the adequacy in the written components in respect to the quality of writing, their relationship and overall direction. The areas of consideration when evaluating are as follows:

**MEDICAL RECORD AUDIT**

**I. DATA BASE**

A. Were the screening tests, history, physical, lab, and/or admission notes complete?

B. Was a thorough chart review undertaken and problemned?

**II. PROBLEM LIST**

A. Were all problems recognized, numbered, and titled? Do problem statements reflect known diagnoses as well as unexplained physiological, symptomatic, physical, and abnormal laboratory findings?

B. Have social and demographic problems been included?

C. Is the list current (updated)? Does it include appropriate inactive and active categories?

D. Have problems been described at the proper
level of refinement?

III. PROBLEM ASSESSMENT AND PLAN FORMULATION
   A. Were all problems acted upon (either positively or negatively) in a manner complementary to existing or resolved problems?
   B. Was adequate, appropriate information and ancillary data (physical, lab, or x-ray) obtained to:
      (1) Evaluate each problem identified?
      (2) Evaluate abnormal physical and historical findings?
      (3) Evaluate positives obtained in screening?
   C. Was an acceptable plan written for each problem?
   D. Did the plan realistically assess the patient's limitations and understanding of the problem?

IV. PROGRESS NOTES AND FOLLOW-UP
   A. Were complications recognized and dealt with; was appropriate follow-up initiated?
   B. Were complicated, interacting problems dealt with on flow sheets individually to fit the case at hand? Were the correct multiple variables chosen for follow-up at appropriate intervals?
   C. Were existing unresolved problems delineated.
in an adequate discharge note and/or summary?

(15:176)

The proper numbering and titling of progress notes make it possible to appraise, through auditing, the quality of data, analysis, and medical performance in any one of the patient's problems. Four premises of a Problem-Oriented Medical Record system audit can be stated as follows:

Premise 1. All the data in the medical record must be associated with a specific problem in order to determine whether the data is fundamental to solving the problem and whether factors such as redundancy, unnecessary delay and lapse in judgment are present.

Premise 2. All the data on any given problem must be easily retrieved in sequence and with complete accuracy.

Premise 3. Conclusions will be much more difficult when a patient has multiple problems. In this particular case, fixed standards of care do not apply and quality must be determined individually.

Premise 4. The dimension of the quality control problem alluded to in #2 and #3 can rarely be assessed until computerization of the data is accomplished. Manual approaches have not after all these years resulted in a widely applicable and practical approach. (28:116) (30:56)

The mechanics of the system for evaluating POMR should be under the guidance of the Utilization Review Committee in the skilled nursing facility. This committee is made up of a panel of physicians, key administrative personnel and med-
cal consultants formed in response to the requirements of Medicare, to establish standards for the utilization of hospital facilities and services. This type of evaluation of the physician by his peers is a definite step in the direction toward monitoring a physician's decision for patient care. This will constitute a positive and constructive change in the medical structure for the future. (18:81-83)

Benefits derived from a well structured evaluation plan will improve quality of care, achievement of objectives, and goals resulting in a closer nurse-patient-family relationship.
CHAPTER III
METHODOLOGY

The material which serves as the research background for this study was collected from the following sources:

1. Available material written by practitioners utilizing the Problem-Oriented Medical Record system.

2. Interview evaluations with 8 physicians, 15 skilled nursing facility administrators, and other professional consultants.

3. Personal observations and opinions, followed by logical conclusions, utilizing Program Evaluation and Review Techniques (PERT) as the managerial method for implementation.

During the last two years I have had the opportunity, as a SNF administrator, to observe and study the interrelationships and learning problems of individuals associated with long-term, chronically-ill patients. These data were gathered by subjective methods and incorporated into the report.
CHAPTER IV
RESULTS AND DISCUSSION

Plan for the Implementation of the Problem-Oriented Medical Record System

Because of the fact that the Problem-Oriented Medical Record system is a relatively recent development (21:7), there is a definite lack of educational knowledge and understanding of the system among skilled nursing facility personnel. Out of a total number of 15 hospital administrators contacted, only 4 had any prior knowledge about the Problem-Oriented Medical Record system. From this group, 2 wanted to learn more about the system and 1 administrator showed interest and desire in instituting the POMR system in his facility in the near future. The overall reticency further emphasized the fact that there is a great hesitation on the part of administration/ownership for change. Therefore, I would conclude that instituting implementation of POMR is likely to require a structured form of concentrated training, education or by legislation.

One can say without hesitation that the implementation of the POMR system must first have the interest and support of the medical staff and key personnel responsible for that installation. This interest must be more than a passive agreement to try it, but a genuine excitement and dynamic
enthusiasm.

Out of 8 key physician Utilization Review Chairmen consulted with, 3 voiced the opinion that if a system such as this would succeed, it must first be instituted in their (the physician's) established practice. Then, as the system is understood and a routine established and their confidence in the system is built up, the desire to change is strengthened and resistance is lessened.

Physicians hesitate on the basis that the Problem-Oriented Medical Record system structure lays open all of the data and decisions for analysis and criticism. (32:33)

Before proceeding further, it would be wise to have well in mind and clearly defined exactly who is interested (physicians, nurses, consultants, and administration) and the extent of their knowledge as well as the level of their commitment and a concrete implementation procedure.

A network model analysis (Program Evaluation and Review Technique) PERT CHART provides an outline to effectively utilize those necessary activities that must be identified and undertaken for the purpose of implementing this system in a skilled nursing facility.

Essentially, it is a method of mapping future activities so that anyone can visualize the total plans of action for a program.

The ideas underlying PERT are not new. PERT was developed in 1959 by the U.S. Navy as a means of providing management control and coordination of the Polaris missile
program. At around the same time, the E. I. Dupont de Nemours Corporation developed a similar technique called the Critical Path Method (CPM). Both the Critical Path Method and the Program Evaluation and Review Technique are now being used in the construction industry and in other industrial enterprises that involve complex planning.

PERT is a form of graphic network analysis consisting of:

1. The development of a model or activity network of a contemplated program or a part of the program.

2. The evaluation of the network and adjustment of it in such a way as to provide a degree of assurance that, if the plan described is followed, there will be a minimum of risk in reaching the objective on time and within the limits of acceptable cost.

3. The use of the network to monitor and control the operation it represents.

(1:9)

PERT uses a special terminology consistently throughout the process. Listed are some key terms necessary for understanding.

Event: A factual statement of completion of an activity or series of activities and not a description of an activity in process.

Activity: The action between events that
consume time and effort, represented on the flow chart by the arrow between events.

Sequence Number: The position of each event in the entire program and its relation to the other events.

Network: A system of diagramming the flow of events from the beginning event to the final events.

To insure the best time, the planners should estimate three different predictions and select the mathematical average, one that considers the possibilities of error and chance.

Minimum Time: The least time required for the activity to occur.

Normal Time: The average estimated time required.

Maximum Time: The estimate of extra time required to provide for unforeseen difficulties.

The formula for average time estimation is:

\[ T_e = \frac{a + \frac{4m}{6} + b}{6} \]

where:
- \( T_e \) is time estimate
- \( m \) is normal time
- \( a \) is minimum time
- \( b \) is maximum time

By utilizing this formula, a fair estimate of the
time required can be made not only for each activity, but also for the entire program. (1:8-33)

This network of completed events provides a total visual picture, indicates what activities are essential for the program, and gives an idea of the flow and estimated time dimension. It provides the essential facts to be communicated about a program (refer to PERT ACTIVITY CHART, p. 23), what needs to be done (refer to Sequence No.), how long it will take (refer to Estimated Time), what aspects have to be coordinated (refer to Determination of Activity), all with a focus on the program's objective of implementation of the Problem-Oriented Medical Record system in 93 days.
## PROGRAM EVALUATION AND REVIEW TECHNIQUE

### PERT ACTIVITY CHART

<table>
<thead>
<tr>
<th>Sequence No.</th>
<th>Determination of Activity</th>
<th>Estimated Time (Days)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Min</td>
</tr>
<tr>
<td>1</td>
<td>Inform key personnel of pertinent information, studies and all available data to instill interest and commitment.</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Key personnel: Hospital consultants, key staff personnel, UR Committee, physicians who have had one or more patients admitted.</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Schedule field visits with facilities utilizing system. Identify obstacles.</td>
<td>3</td>
</tr>
<tr>
<td>3</td>
<td>Schedule meetings to consider POMR with key personnel, outline size and scope of project.</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>STAGE I</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Decision to install POMR, Allocation of priority events. Pilot study of full conversion.</td>
<td>1</td>
</tr>
<tr>
<td>5</td>
<td>Administrators role/allocation of priority events and task analysis.</td>
<td>3</td>
</tr>
<tr>
<td>6</td>
<td>Initial development outline; determine specific objectives and anticipated results and obstacles for all personnel.</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>STAGE II</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Medical Records Consultant role/pre-implementation audit, identify record deficiencies, auditing system, develop new POMR forms, submit for approval. Evaluate task analysis.</td>
<td>10</td>
</tr>
<tr>
<td>No.</td>
<td>Description</td>
<td>Stages</td>
</tr>
<tr>
<td>-----</td>
<td>-----------------------------------------------------------------------------</td>
<td>--------</td>
</tr>
<tr>
<td>8.</td>
<td>Director of Nurses role/evaluate staff, determine activity time, education, anticipate areas of confusion and follow-up.</td>
<td>10</td>
</tr>
<tr>
<td>9.</td>
<td>Director of Activities role/support obtained from OT consultants, PT consultants, speech consultants</td>
<td>3</td>
</tr>
<tr>
<td>10.</td>
<td>State Department of Health's support</td>
<td>3</td>
</tr>
<tr>
<td>11.</td>
<td>Dietitian's role/support</td>
<td>3</td>
</tr>
<tr>
<td>12.</td>
<td>Social worker/s role/support</td>
<td>3</td>
</tr>
<tr>
<td>13.</td>
<td>Third party payer's support</td>
<td>3</td>
</tr>
<tr>
<td>14.</td>
<td>Follow-up on physician's role, arrange personal conferences to solicit and introduce project, emphasizing conversion to POMR in their established practice</td>
<td>10</td>
</tr>
<tr>
<td>15.</td>
<td>Key staff personnel (cadre training) oriented to their scope and role, development of manuals, report flow charts and individual conferences</td>
<td>3</td>
</tr>
<tr>
<td>16.</td>
<td>Evaluate level of education, willingness of present personnel.</td>
<td>1</td>
</tr>
<tr>
<td>17.</td>
<td>Recruit, orient and train additional personnel if necessary</td>
<td>3</td>
</tr>
<tr>
<td>18.</td>
<td>Obtain supplies and equipment</td>
<td>1</td>
</tr>
<tr>
<td>19.</td>
<td>Program personnel training</td>
<td>10</td>
</tr>
</tbody>
</table>

**Task analysis:**

**STAGE V**

1. Program training #1
2. Program training #2
3. Program training #3

Pre and post tests admin-
<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>20.</strong> Support of key physicians secured.</td>
<td>3</td>
</tr>
<tr>
<td><strong>21.</strong> Pre-operational preparation and training completed</td>
<td>1</td>
</tr>
<tr>
<td><strong>22.</strong> Admission of all patients utilizing POMR and start converting existing records, Guideline for converting</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>STAGE VI</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>23.</strong> Ongoing educational and auditing program</td>
<td>1</td>
</tr>
</tbody>
</table>
NOTE:

Event -- Events are shown on the network diagram by numbers which correspond with sequence numbers on PERT Activity Chart, pp. 23-25.

Activity -- Activities determine the time, effort and personnel necessary to move from one event to the next. PERT Activity Chart.

Estimate time -- Estimated time required for each activity and the entire program.

PERT NETWORK DIAGRAM
ESTIMATED TIME OF 93 DAYS
FOR THE IMPLEMENTATION OF
PROBLEM-ORIENTED MEDICAL
RECORD SYSTEM

FIGURE 1.
An Analysis of the Facilitators and Inhibitors in the Implementation of the System

A Problem-Oriented Medical Record system that may expose health practitioners to criticism presents some element of threat and hesitation for change. Most individuals do not request change; they would rather keep things just the way they are, even when change is necessary.

In a skilled nursing facility it is usually the administrator/owner who is delegated the role to overcome this inertia, to prod and pressure the system, eliminate the complacency and solve the problem. By making his dissatisfaction known and by upsetting the "status quo," he energizes the problem-solving process. (13:7)

APPLICATION OF THE PLANNED INNOVATION MODEL

STAGE I
RELATIONSHIP
A viable relationship must be developed with key personnel, members of the Utilization Review Committee, physicians who have admitted patients at the facility. A secure and reasonably well delineated helping role is an essential position from which to start. Clearly define who is interested, degree of knowledge, and level of commitment (refer to PERT ACTIVITY CHART, STAGE I, Sequence Nos. 1 and 2).

STAGE II
DIAGNOSIS
Once established in the system, em-
phasis must turn to the problem, implementation of the Problem-Oriented Medical Record system. Key personnel must be aware of their needs and articulate their needs as problem statements. Change should not be made just for the sake of change. Clearly defined goals must be justified. Decide early to what extent the POMR will be implemented and in what phases. That is, should implementation be attempted on a hospital-wide basis or pilot study (refer to STAGE II, Sequence Nos. 3 and 4).

With a well defined problem, the key personnel need to be able to identify and obtain resources relevant to solutions. Clear lines of responsibility and authority must be established. Each individual will be only as effective as his knowledge of the system and of the implications allowed (refer to STAGE III, Sequence Nos. 5-13).

With a defined problem and relevant information, the key personnel need to be able to derive implications, generate a range of alternatives, and set-
S\textsc{tage} V
\textsc{gaining}
\textsc{acceptance}

Even a good solution needs adaptation and reshaping to fit the special characteristics. The timetable should be kept as flexible as possible to permit additional education where necessary and redraft of procedures where indicated (refer to S\textsc{tage} V, Sequence Nos. 16-19).

S\textsc{tage} \textsc{vi}
\textsc{stabilization}
\textsc{and self-}
\textsc{renewal}

Finally, the key personnel need to develop an internal capability to maintain the innovation and continue appropriate use of the system (refer to S\textsc{tage} VI, Sequence Nos. 20-23).

Modified from source (13:12-13)
COMPARISON OF THE COMPONENTS OF POMR IN THREE SETTINGS
WEED SYSTEM, DEPT. OF MENTAL HYGIENE SYSTEM; AND SKILLED NURSING SYSTEM

The Problem-Oriented Medical Record system developed for this study is an expansion of the system originated by Dr. Lawrence L. Weed and modified by the Department of Mental Hygiene (DMH) March 15, 1974.

TABLE 1.

<table>
<thead>
<tr>
<th>WEED POMR SYSTEM (Acute Hospital)</th>
<th>DMH POMR SYSTEM (Mental Hospital)</th>
<th>SNF POMR SYSTEM (Long-Term Hospital)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Step 1: Data Base</strong></td>
<td><strong>Data Base</strong></td>
<td><strong>Data Base</strong></td>
</tr>
<tr>
<td>Patient profile</td>
<td>Identification and personal data</td>
<td>Chief complaint</td>
</tr>
<tr>
<td>History</td>
<td>Medical/developmental history</td>
<td>Patient profile</td>
</tr>
<tr>
<td>Physical</td>
<td>Psychiatric evaluation</td>
<td>Psychological state</td>
</tr>
<tr>
<td>Laboratory</td>
<td>Social/psychological evaluation</td>
<td>Past history</td>
</tr>
<tr>
<td></td>
<td>Physical examination</td>
<td>Family history</td>
</tr>
<tr>
<td></td>
<td>Lab, x-ray, dental</td>
<td>Present illness</td>
</tr>
<tr>
<td></td>
<td>Prior treatment records</td>
<td>Current meds</td>
</tr>
<tr>
<td></td>
<td>Updates to the data base</td>
<td>Diet history</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Present activity level</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Present physical state</td>
</tr>
<tr>
<td><strong>Step 2: Problem List</strong></td>
<td><strong>Problem List</strong></td>
<td><strong>Problem List</strong></td>
</tr>
<tr>
<td>Number and title problems</td>
<td>Behavior, self-help, social</td>
<td>Social behavior</td>
</tr>
<tr>
<td></td>
<td>Emotional, signs, symptoms</td>
<td>Psychiatric</td>
</tr>
<tr>
<td></td>
<td>Physiological findings</td>
<td>Medical findings</td>
</tr>
<tr>
<td></td>
<td>Abnormal lab, environmental</td>
<td>Diagnosis</td>
</tr>
<tr>
<td></td>
<td>Other diagnostic studies and pro-</td>
<td>Physiological</td>
</tr>
<tr>
<td></td>
<td>cedures</td>
<td>Symptoms, phy.</td>
</tr>
<tr>
<td></td>
<td>Diagnosis when proven</td>
<td>Abnormal lab</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Demographic</td>
</tr>
</tbody>
</table>
### Step 2: Initial Plan

<table>
<thead>
<tr>
<th>Diagnostic</th>
<th>Objectives</th>
<th>Problem Assessment and Plan Formulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapeutic</td>
<td>State in observable, measurable terms</td>
<td>Diagnostic</td>
</tr>
<tr>
<td>Patient education</td>
<td>Set time frame to meet objective for each problem</td>
<td>Therapeutic</td>
</tr>
</tbody>
</table>

### Step 4: Progress Notes

<table>
<thead>
<tr>
<th>Narrative notes</th>
<th>Plans</th>
<th>Progress Notes and Related Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subjective data</td>
<td>State activities, method, resources, treatment</td>
<td>Subjective data</td>
</tr>
<tr>
<td>Objective data</td>
<td>State method of evaluation and review data</td>
<td>Objective data</td>
</tr>
<tr>
<td>Assessment Plans</td>
<td></td>
<td>Assessment Plan</td>
</tr>
<tr>
<td>Flow sheet</td>
<td></td>
<td>Flow sheet</td>
</tr>
<tr>
<td>Discharge notes</td>
<td></td>
<td>Acute Chronic</td>
</tr>
</tbody>
</table>

### Step 5: Interdisciplinary Notes and Summaries

<table>
<thead>
<tr>
<th>Interdisciplinary Notes and Summaries</th>
<th>Discharge Summaries</th>
</tr>
</thead>
<tbody>
<tr>
<td>Progress notes</td>
<td>Problem as identified</td>
</tr>
<tr>
<td>Quarterly summaries</td>
<td>Condition on discharge</td>
</tr>
<tr>
<td>Special recordings</td>
<td>Prognosis</td>
</tr>
<tr>
<td>Interpretive summaries of evaluation tools and progress graphs</td>
<td>Duration of disability</td>
</tr>
<tr>
<td>Release summary</td>
<td>Recommendations</td>
</tr>
</tbody>
</table>

The observations made here are based on the comparison of the components in the above three settings.

The medical record of the patient with a long-term illness grows into a vast accumulation of data, which includes the usual history, physical examination, laboratory procedures, and x-rays. The record must also contain social factors that may affect the patient's progress, such as those related to home, vocation, finances, interpersonal relationships, expectations and goals.
Usually, the problems are not all medical, but include those that are social and demographic.

In chronic illness, the approach to patient care can be more objective when resources in dealing with a situation or in meeting difficulties can be identified, including his premorbid functioning level and available resources of the community and the institution.
The Problem-Oriented Medical Record system brings a logical method to patient care. It allows physicians to gather data, define and follow patient problems one by one. This system makes it possible to assess the quality of care actually given patients. It can be used to transform a philosophy of education into specific and attainable goals.

Basic Requirements:

Development of a data base,
List problems by number and title on a complete list,
Develop plans for each problem,
Record progress of specific problems by problem number and title.
The POMR system in a mental health setting emphasizes identification of the client/patient's problems, development of objectives and plans for each problem. The re-
cording of observations of the client/patient's progress and response as it relates to each problem.

Basic Requirements:

Development of a data base.
List problems by number and title on problem list.
Set objectives for each problem.
Develop plans for each problem to meet the objectives.
Record progress of specific problems by number and title.
Reference all records to number and title.
The POMR system for the chronic illness approach to patient care can be more objective, if resources are identified, including premorbid functioning level and the avail-
able resources of the community and the institution.

Basic Requirements:

First element is an adequate data base.
Problem list developed from specific and significant information from the data base.
Specific plans for each problem, either for management or further evaluation.
Progress notes, recorded in chronologic sequence and keyed to a specific problem by title.
Condition and prognosis of patient on discharge.
GENERAL METHOD DIAGRAM

FIGURE 5.

PATIENT ADMISSION

RECORD

DATA BASE Step I

CREATE

PROBLEM LIST Step II

INITIAL PATIENT WORKUP

WRITE

PROBLEM Step III

ASSESSMENT FOR EACH PROBLEM

WRITE

PHYSICIAN'S ORDERS

SUBSEQUENT RECORD ENTRIES

WRITE

PROGRESS NOTES Step IV & RELATED DATA BY # AND TITLE OF EACH PROBLEM

WRITE

HEALTH CARE TEAM PROGRESS NOTES (Physician, nurse, allied health personnel)

REVISE OR ADD TO

YES

PROBLEM LIST

NO

IS PROBLEM RESOLVED?

YES

FINAL NOTE & ORDERS

NO

ARE YOU DISCHARGING PATIENT?

YES

DISCHARGE SUMMARIES Step V

NO

DO YOU WANT TO WRITE OR DISCONTINUE ORDER?

WRITE

PHYSICIAN'S ORDERS BY # AND TITLE OF EACH PROBLEM

Modified from Medical Record News
STEP I  Define the types of data to be collected.

STEP II  Analyze and synthesize the data in order to formulate a set of problems.

STEP III Develop a plan for each problem.

STEP IV Follow up and identify how the planned action has influenced the patient. Display all steps simply and briefly in the record so that other physicians, nurses, and allied health personnel can use the record. Revise and update all data when necessary.

STEP V When the patient is transferred from one physician to another, from one facility to another, or discharged home, a projected probable course to follow and defined end points to guide therapy will determine summary plan.
COMPONENTS OF A PROBLEM-ORIENTED MEDICAL RECORD SYSTEM FOR A SKILLED NURSING FACILITY

TABLE 2.

I. Establishment of a Data Base

A. History
   1. Chief complaints
   2. Patient profile (related social data, family history)
   3. Present illness (or illnesses)
      a. Problem undiagnosed
         or
      b. Relapse of chronic disorder
         Both a and b recorded with symptomatic information, objective data, previous treatment information, significant negatives.

   4. Past history
   5. Family history
   6. Systemic review

*B. Psychological State
*C. Current Medications
*D. Diet History
*E. Present Activity Level and Limitations

F. Physical Examination
G. Base Line Laboratory Examination

II. Problem List

Formulation of all problems

A. Past and Present Problems
   1. Social
2. Psychiatric
3. Medical
   a. Diagnosis
   b. Physiological finding
   c. Symptom or physical finding
   d. Abnormal lab. finding
4. Demographic

B. Active or Inactive (resolved)

III. Problem Assessment and Plan Formulation
A. Diagnostic
   1. Further data required
   2. Purpose of data ordered
B. Therapeutic Treatment
   1. Explanation to patient
   2. Other personnel to be involved
   3. Patient responsibility
C. Patient Education

IV. Progress Notes and Related Data
Follow up on each problem titled, dated and numbered
A. Subjective Data (S)
B. Objective Data (O)
C. Assessment (A)
D. Plan (P)
   1. Diagnostic
   2. Therapeutic
   3. Patient education
E. Flow Sheets (special form of progress note)
1. Acute, rapidly changing clinical situation e.g., burn patient: Patient in shock fluid balance.

*2. Chronic, long-term problem
   a. Monitoring function
   b. Baseline parameters

V. Discharge Summaries
   A. Problem as Identified or Problem List Numbered and Titled
      1. Symptomatic
      2. Objective
      3. Treatment
         For each numbered problem.
   *B. Condition on Discharge
   *C. Prognosis
   *D. Duration of Disability
   *E. Recommendations
      1. Where discharged
      2. When to return for follow-up
      3. Medications on discharge

*Indicates any deviation from the Weed POMR system.

Particular emphasis should be placed on the components of the Problem-Oriented Medical Record system, originated by Dr. Weed, focusing on acute care and the modification of these components for a skilled nursing facility.

A long-term, chronically-ill patient usually has a number of problem areas, psychiatric, social and demographic, as well as past and current physical complaints. Unlike
acute care, the hospital stay is usually over an extended period of time.

In dealing with the emotional aspects of a problem, the physician and the patient can look more objectively at the recorded behaviors reflected in the patient's emotional reaction. Such a record does not necessarily imply any value judgment by the physician or patient, but rather permits him to take an overall, retrospective evaluation at some of the patient’s behaviors and thereby obtain a better perspective of the effectiveness of treatment. (1:277)
CHAPTER V

DISCUSSION, RECOMMENDATION AND IMPLICATIONS

Properly developed, the Problem-Oriented Medical Record system provides a logical, explicit description of all the patient's problems, the current treatment for each problem and the plan of the health care team in relation to each problem. Reviewing such a record is an efficient means of evaluating the team's performance and provides the immediate feedback on the quality of patient care. Such a record audit thus becomes both an educational experience for health care personnel and an essential instrument for quality control of health care services. (23:512)

The heart of this recording system lies not in memory and the recall of facts, but in the practitioner's capacity to analyze data in an orderly and systematic manner. (28:8)

Advantages of the Problem-Oriented Medical Record System

Prevents neglect of all the minor problems. Few chronically-ill patients have only one problem, medical or non-medical, that needs attention. Since medicine in the United States has been crisis-oriented, there is a tendency to focus on the acute problems, thus other problems such as the chronic diseases that may seem minor at one time and become acute through neglect are overlooked. (12:15)
Although the physician and other members of the health team, working with him in the treatment of a long-term illness, may have the goals of management well in mind, their concept may vary widely. The Problem-Oriented Medical Record system requires that a goal for each problem be established and entered in the medical record. A written statement of the goal clears up any confusion, not only for members of the health team, but also for the patient and the patient's family.

Promotes clearer communication and continuity of care. The POMR system strongly emphasizes the importance for a chronologic sequence of the progress notes. These are entered in one section of the medical record and all team members are encouraged to use terms and language common to all members. Under the "non-system" of recordkeeping, the physician as team leader spends a great deal of time seeking information from team members. Integration of the information is discouraged by this method. Under the POMR system, each member has the opportunity to express himself in the multi-disciplinary progress notes, by which he can communicate effectively with the physician and other members. (1:276)

Facilitates the assessment of abilities. Medical education involves acquisition of knowledge, skills and attitudes. In the acquisition of knowledge or cognitive phase, learning involves facts, communication, synthesis, evaluation and other functions. Unfortunately, too much emphasis
is placed on facts rather than the basic concepts of management problem solving. Problem-oriented systems encourage logical thought processes, planning and action. (1:277)

Simplifies record audit. The hospital stay of most chronically-ill patients is usually over 30 days, long enough to require an audit or at least one or more utilization reviews conducted by the U.R. Committee. Reviewing the Problem-Oriented Medical Record system would take only a fraction of the time needed for reviewing the record and present more clearly the problem or problems that require further hospitalization, as the progress notes specifically indicate the problem to which they refer.

Insures adequate documentation for third-party payers. Documentation of nursing care is valuable not only to the members of the health team in planning and evaluating the care, but also to the third-party payer system. This documentation of services rendered to patients by certified health agencies is a contractual obligation between the provider and the Social Security Administration. Services rendered must be in accordance with interpretations of the Medicare Law and must be recorded in a manner that reflects the skilled care being given. (26:50)

In our concern for needed health care, however, the delivery of service is often dependent on our concern for the third-party payment. The question, "Will it be paid for?" will influence greatly, "Just what is needed?"

Medicare Law Section 405.1024, Conditions of Partici-
pation, provides a standard for evaluation and review of nursing care.

One would assume that with this background the nurse's charting would reflect the skilled care she is giving. But if the notes reflect assisting the patient in the routines of daily living, e.g., assistance in walking, getting in and out of bed, bathing, use of toilet facilities, dressing and feeding that would ordinarily be self-administered, the notes would reflect custodial care. (9:22). It is therefore not reasonable to expect payment for skilled services, when custodial services are being documented.

Skilled nursing care is a continuous process of assessing, planning, implementing and evaluating activity that effects a change in the patient's health needs. What has been recorded reflects what has been done. If skilled nursing care is not recorded, we cannot expect patients, physicians, or third-party insurers to assume it was given.

**Implications of the Problem-Oriented Medical Record System**

The structured POMR provides a focus for constructive action in improving a variety of difficulties now besetting medicine, inefficiency in practice (as evidenced by the excessively strenuous burdens upon most physicians and differences in the quality and amount of care received by the patients), lack of continuity of care, inefficiency in education, and the absence of meaningful audit in the practice of medicine. (28:105)
The interdependence of social and medical problems is immediately revealed by a complete list of problems. Common-sense approaches to total care are facilitated by a complete problem list. Until well conceived problem lists are the rule rather than the exception, fragmentation of health care in today's hospitals will continue. (28:106) The physician must learn how to move easily from a single-minded focus on one problem to the total problem list and the interrelations of many problems.

The Problem-Oriented Medical Record system becomes a dynamic, structured framework for facilitating comprehensive care. The system prevents neglect of minor problems; lessens ambiguity of management goals; promotes clearer communications, continuity of care, professional behavior of the health team, objectivity of the physician and patient; helps the physician as a team leader; and simplifies audits.
CHAPTER VI
SUMMARY AND CONCLUSION

The purpose of this study was to extend Dr. Weed's Problem-Oriented Medical Record system by modifying this method for implementation in a skilled nursing facility.

This project investigated the development and feasibility for implementation of the system in a three-phase approach:

1. The Problem-Oriented Medical Record System Modification.
2. An Analysis of the Facilitators and Inhibitors.
3. A Plan for the Implementation of the Problem-Oriented Medical Record System.

The material compiled for this study consisted of available literature written by practitioners utilizing the system, interviews with administrative peer groups, using management techniques for implementation, and personal observations followed with logical conclusions.

The systematic method of recording utilized in POMR illustrates the manner in which the system preserves recorded data in a standardized, explicit form. Familiarity with and use of this system are essential to all members of the health care team. This method will have implications for better, more comprehensive health care, as well as for im-
proved methods of educating health care practitioners and evaluating the quality of patient care.
BIBLIOGRAPHY


19. _____. Medical Records, Patient Care and Medical Education. IR J Med Sci t: June 1964, pp. 271-282.


APPENDIX

A. Hospital Record

DATA BASE

ADMISSION ASSESSMENT

ADMISSION DATE: February 26, 1973
SCHEDULED ADMISSION: No
PATIENT ARRIVED FROM:

SOURCE: Patient

CHIEF COMPLAINT: "I have no trouble."

PATIENT PROFILE: This is a 44-year-old, obese, white, married female whose two children are in a foster home. This patient was certified at Orange County Medical Center with a history of being violent, breaking furniture and being quite irrational. This patient was examined by a staff psychiatrist who noticed that she was quite delusional. She felt people were going to kill her. At times she was evasive and using denial. She has been taking Tenuate for several months and there is a possibility that she is abusing that drug.

PSYCHOLOGICAL STATE: On admission she appeared angry and expressing persecutory ideation regarding neighbors and social worker. During examination she was freely verbal, cooperative and pleasant but guarded.

PAST HISTORY: Birth and early development, full-term, normal, spontaneous delivery with normal development. Drugs: Has had Librium 10 mg t.i.d. for nerves the last several weeks prior to admission. Tenuate 4-6 tabs a day for the past 3 months. Tobacco: One pack a day. Sleep: Fair. Hysterectomy in 1968. Previously hospitalized in Metro State Hospital several times during the past 10 years.

FAMILY HISTORY: Father deceased at 64 from cirrhosis of the liver. Was a rough and terrible truck driver who drank, but was warm and kind when around. Mother deceased at age 68 of cancer of the uterus. Paternal grandparents: Unknown to patient. Siblings: Patient has a brother 4 years her senior. They get along fine, he is married and lives in Wyoming.

PRESENT ILLNESS: Affect blunted, mood suspicious and belligerent. Denies hallucinatory experiences and there is much denial and evasiveness.

CURRENT MEDICATIONS: Has had Librium 10 mg t.i.d. for nerves the last several weeks prior to admission.
Diet History: General nutrition, well developed, well nourished, obese.

Present Activity Level: Temperament, quick-tempered, forgives easily. Hobbies: Enjoys crocheting and used to bowl and swim. Interpersonal relationships.

Present Physical State:

Cardiovascular: Tachycardia 1-4 times daily, duration 1-5 minutes related to preoccupation.


Nervous System: No pathological findings.

Physical Exam: Enclosed report.

Laboratory Data: Enclosed report.
PROBLEM LIST

<table>
<thead>
<tr>
<th>Date</th>
<th>Prob. No.</th>
<th>Problem</th>
<th>Date Resolved</th>
</tr>
</thead>
<tbody>
<tr>
<td>2/26/73</td>
<td>0</td>
<td>Schizophrenia, paranoid type</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td></td>
<td>Delusions: Feels as if outside social worker, police, husband, and neighbors are trying to kill her.</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td>Hostile: Aggressive, breaking up her furniture.</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td>Evasive: Antisocial; retreats to her bed whenever possible.</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
<td>Abuse of drug: Tenuate.</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
<td>Unable to care for children (both in foster homes).</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td></td>
<td>Habeas corpus writ requested by patient.</td>
<td>2/28/73</td>
</tr>
<tr>
<td>3/1/73</td>
<td>7</td>
<td>Rash on neck and chest (patient says due to Thorazine).</td>
<td>3/5/73</td>
</tr>
</tbody>
</table>

Ph.D.
M.D.
<table>
<thead>
<tr>
<th>Date</th>
<th>No.</th>
<th>Objectives</th>
<th>Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>2/26/73</td>
<td>1</td>
<td>Eliminate delusions within 2 weeks</td>
<td>1 1 1 Stelazine 10mg. t.i.d., Thorazine</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2 00mg. t.i.d., Artane 2mg. t.i.d. x 14 days</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1 1 2 Group psychotherapy 3x week with Dr. Happy x 14 days</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Control acting out behavior within 2 weeks</td>
<td>2 1 1 Same as 1.1.1.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Improve personal interactions within 2 weeks</td>
<td>2 1 2 Body movement therapy, 1 hour daily with Slep Slip, R.T., 2 weeks</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tenuate abuse, deferred 2/26</td>
<td>3 1 1 Bowling 1 x week and O.T. 2 x with R.U. Fast, O.T., 2 weeks</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Get patient to take interest in children within 2 weeks</td>
<td>3 1 2 Same as 1.1.2.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Proceed immediately 2/27 with patient's request (writ)</td>
<td>4 1 1 Referred to E. Central MHR post hospitalization</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>5 1 1 C. Busy, PSW will contact foster home re: patient-children relationship within 5 days</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>6 1 1 Send patient to 2/27 Forensic Clinic with M., Dear, M.D.</td>
</tr>
</tbody>
</table>
3/1/73 Eliminate rash within 5 days

2/28 6 1 2 Send patient to L.A. Superior Court on 2/28

3/5 1 1 Refer to Dr. Speed

7 1 2 Medication changed (due to allergy to Mel-laril) 100 mg t.i.d. x 14 days

3/1/73 Eliminate rash within 5 days

Send patient to L.A. Superior Court on 2/28

Refer to Dr. Speed

Medication changed (due to allergy to Mel-laril) 100 mg t.i.d. x 14 days
<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Prob.</th>
<th>Entry</th>
</tr>
</thead>
<tbody>
<tr>
<td>2/26/73</td>
<td>6</td>
<td>Requested a writ, after being seen by Mental Health Counselor.</td>
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<td><strong>[Signature] U. P. Chinn</strong> M.H.C</td>
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<td></td>
<td>0</td>
<td>8:45 a.m. Admission team Conference with patient.</td>
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<td><strong>[Signature] K. Mary PT</strong> PT</td>
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<td></td>
<td>3</td>
<td>10:00 a.m. Patient had to be gotten out of her bed numerous times during this a.m.</td>
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<td><strong>[Signature] A. Thrift RN</strong> RN</td>
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<td></td>
<td>3</td>
<td>8:00 p.m. Patient Jane Doe tried to talk to patient. Patient walked away and sat in corner of day room by self.</td>
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<td><strong>[Signature] A. Thrift RN</strong> RN</td>
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<tr>
<td>2/27/73</td>
<td>1,2</td>
<td>6:15 a.m. Patient had to be asked the second time to get up this a.m. Patient jumped out of bed, pushed it against wall and stated, &quot;I suppose you want to kill me, too.&quot;</td>
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<td><strong>[Signature] A. Thrift RN</strong> RN</td>
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<td></td>
<td>6</td>
<td>9:00 a.m. Forensic Clinic (writ). Forensic Clinic recommends discharge.</td>
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<td><strong>[Signature] M. Den M.D</strong> M.D.</td>
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<td></td>
<td>1,2</td>
<td>10:00 a.m. Refused to attend psychotherapy group. When asked, just turned and walked away.</td>
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<td><strong>[Signature] S. Hayney M.D</strong> M.D.</td>
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<td>1:00 p.m. Refused to go bowling with group. Asked, &quot;What for?&quot;</td>
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<td>1,2</td>
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<td>1:00 p.m. Refused to go bowling with group. Asked, &quot;What for?&quot;</td>
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</table>
2 4:00 p.m. Pushing chairs in day room, in an angry manner, on way to treatment room for medication.

P Whal PT

2/28/73 6 6:30 a.m. Transfer patient court, per writ.

K Merry PT

6 11:30 a.m. Court denied writ, patient remanded to hospital for completion of treatment. Patient thinks the court is unfair. "Judge doesn't know me!"

A Lynn PTII

3 7:30 p.m. Volunteer Group having a party on the ward. Patient watching, but will not join the group.

P Whal PT
PHYSICIANS ORDERS

<table>
<thead>
<tr>
<th>Date</th>
<th>Prob. No.</th>
<th>Order Details</th>
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<tbody>
<tr>
<td>2/26/73</td>
<td>1,2</td>
<td>Stelazine 10 mg t.i.d. x 14 days</td>
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<td></td>
<td></td>
<td>Thorazine 200 mg t.i.d. x 14 days</td>
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<td></td>
<td>1,2</td>
<td>Artane 2 mg t.i.d. x 14 days</td>
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<td></td>
<td>1,2</td>
<td>Group psychotherapy 1 hr. 3x week with J. Happy, Ph.D. for 2 weeks</td>
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<td>Body movement therapy 1 hr. daily with Slemp Slip, RT for 2 weeks</td>
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<td>2</td>
<td>Bowling 1x week and O.T. 2x week with R. U. Fast, O.T., for 2 weeks</td>
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<td>3</td>
<td>Miss Busy, PSW contact foster home re: patient-children relationship.</td>
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Noted 9:10 a.m.

2/27/73  6  Send patient to Forensic Clinic

2/28/73  6  Send patient to court, per writ

3/1/73   7  DC Thorazine because of allergy.

1,2      Mellaril 100 mg t.i.d. x 14 days

Noted 8:15 a.m.
Discharge patient with 14-day supply of medication; Stelazine 10 mg t.i.d., and Artane 2 mg t.i.d.

R. Smith M.D. M.D.
PHYSICAL EXAMINATION

Height: 5'2"  Weight: 159  Age: 44

General Observation: Obese, fair complexion
(Build, development, nutrition, evidence of injury)

Cooperative, sits with eyes closed
(Activity, cooperation, responsiveness)

Skin: Dry without lesions

Head: Normocephalic  Facies: symmetrical

Scalp: Hair dry

Ears: No anomalies - clean bilaterally

Nose: No obstruction, no discharge

Eyes: Perla fundi - benign EOM intact

Mouth: Multiple extractions

Throat: Tonsils absent

Neck: Supple without masses

Chest: Symmetrical

Breasts: Large pendulous without masses

Lungs: Clear to P & A

Heart: RSR without friction rub-thrill

Vascular system: Physiological

Pulse: (96) full & regular

Blood pressure: 100/70 supine

Abdomen: Obese wall without LSK felt, B S Active, old hysterectomy scar without masses, nontender

Genitalia: Deferred at patient's request

Spine: No abnormality
REQUEST

Ward: 000  Doctor: Speed  Date: 2/26/73

X-Ray Requested: Chest

Chief Complaint, History and Clinical Impression:

Routine Chest X-ray

REPORT

No acute lung pathology

Impression: Chest Disease, None

Date: 2/26/73  Radiologist: [Signature]

G. U. Clearly, M.D.

Problem No. & Title: