

PROBLEM-ORIENTED MEDICAL RECORD (POMR)

The POMR as initially defined by Lawrence Weed, MD, is the official method of record keeping used at Foster G. McGaw Hospital and its affiliates. Many physicians object to its use for various reasons - it is too cumbersome, inhibits data synthesis, results in lengthy progress notes, etc. However, the proper use of the POMR does just the opposite and results in concise, complete and accurate record keeping. A brief overview of the salient features of the POMR will be helpful.

The basic components of the POMR are:

1. Data Base - History, Physical Exam and Laboratory Data
2. Complete Problem List
3. Initial Plans
4. Daily Progress Note
5. Final Progress Note or Discharge Summary

NOTE: 1, 2 and 3 above must be completed by the admitting physician.

1. **Data Base:** The importance of the Data Base is obvious and must include a complete history and physical exam. Many hospitals include certain routine laboratory studies (CBC, SMAC, EKG, chest x-ray, urinalysis, etc.) for each patient admitted. If these are available to the admitting physician, they are to be included in the initial Data Base along with a history and physical. As additional information is collected it is added to the Data Base.
2. **Complete Problem List:** After the admitting physician performs the history and physical, reviews the basic laboratory data and records the data base, the Problem List is constructed and recorded. The construction of a Problem List is the initial step (for the next step, see number 3 - Initial Plans) of what physicians "really do". That is, once they have seen the patient, physicians think about and define "what is wrong with the patient" or "what are this patient's problems."

Problems are either active or inactive (inactive problems are usually prior, resolved medical or surgical illnesses that are still important to be remembered). Dr. Weed had defined an active problem as anything that requires management or further diagnostic workup. Physicians often get caught up in defining Problems and Problem Lists, accusing each other of lumping, splitting, etc. This is unnecessary. Important facts to be noted in constructing a problem list are these:

- A. A problem should be defined at its highest level of defensibility. Consider, for example, a beginning medicine clerk who admits a patient with vomiting and confusion. On physical exam the patient is found to have muscle twitching and a pericardial friction rub. The initial lab data reveals a BUN of 100 and a potassium of 7.0. The student lists each of these abnormalities as a separate problem. This listing of six problems tells us that the beginning student does not recognize that all of these are manifestations of one problem, uremia. A second-year resident might have recorded the Problem List as having only one problem, uremia, and included all the other abnormalities under that problem. Both Problem Lists are acceptable. The second-year resident is merely reflecting a higher degree of understanding. The following day the clerk's Problem List could be modified to facilitate more precise (and less lengthy) daily progress notes.

Prob.#	Date Entered	Problem List	Problem Resolved
1	5/2/84	BUN <u>5/3</u> →	uremia
2	5/2/84	K <u>5/3</u> →	See #1
3	5/2/84	Muscle Twitching <u>5/3</u> →	See #1
4	5/2/84	Pericardial Friction Rub <u>5/3</u> →	See #1
5	5/2/84	Vomiting <u>5/3</u> →	See #1
6	5/2/84	Confusion <u>5/3</u> →	See #1

Resolving problems 2-6 under 1, uremia, allows one daily progress note to be written for that problem and tells an observer reading the patient's chart that all the signs and symptoms in problems 2-6 are related to manifestations of uremia. The date 5/3 tells the observer to see the notes of that day to explain the redefining of the Problem List.

- B. The Problem List must include all abnormalities noted in the initial data base. Again, each abnormality need not be separately recorded (see above example).
- C. The Problem List is refined as problems are either resolved or further defined.
 1. Example--Problem Resolved: A patient is admitted with a fever and cough productive of a yellow sputum which on Gram stain reveals Gram positive intracellular diplococci. The patient is treated for seven days with penicillin and the patient's problem clinically and radiologically resolves.

Prob.#	Date Entered	Problem List	Problem Resolved
1	5/2	pneumococcal pneumonia <u>5/9</u> →	

The date 5/9 refers an observer to that date's progress note which will explain why the problem is considered resolved.

2. Problem Further Defined: Consider the first example of the patient with uremia. On day 5/7 a renal biopsy is done which reveals the etiology of the renal failure. The Problem List would then show:

Prob.#	Date Entered	Problem List	Problem Resolved
1	5/2	BUN <u>5/3</u> → Uremia <u>5/7</u> → Secondary to membranous glomerulonephropathy	

Again the date of 5/7 will refer the reader to the progress note for that day which should reveal the result of the renal biopsy.

- D. If the initial data base is incomplete, the Problem List must state so.

EXAMPLE: A female patient who is admitted with upper GI bleeding has not had a pelvic exam in 2 years. A pelvic and Paps are not done on admission because the patient is unstable. The problem list must include a problem that states:

Prob.#	Date Entered	Problem List	Problem Resolved
2	5/2	Incomplete Data Base Pelvic/Paps Not Done	

Once the patient is stable and the pelvic exam/Pap smear is done, the problem is resolved.

Prob.#	Date Entered	Problem List	Problem Resolved
2	5/2	Incomplete Data Base <u>5/9</u> → Pelvic/Paps Not Done	Pelvic/Paps Done-Normal

- E. The Positive Review of Systems: Many physicians wonder what to do with the patient who answers affirmatively for every question asked in the review of systems. Does each positive have to be recorded separately? Obviously not!

EXAMPLE: For an elderly, lonely female who is admitted with a hip fracture and whose physical exam is normal except for the hip and whose answers are positive for every question asked in the review of systems, the physician could list the problems: #1 - Fracture left hip, and #2 - Positive review of systems. Or, recognizing that all these affirmatives may be manifestations of depression, the physician could list #2 - Depression.

3. **Initial Plans:** The next process that a physician undertakes after deciding "what is wrong" is "what to do about what is wrong." This is the initial plan and must be written by the admitting physician after the Problem List is constructed.

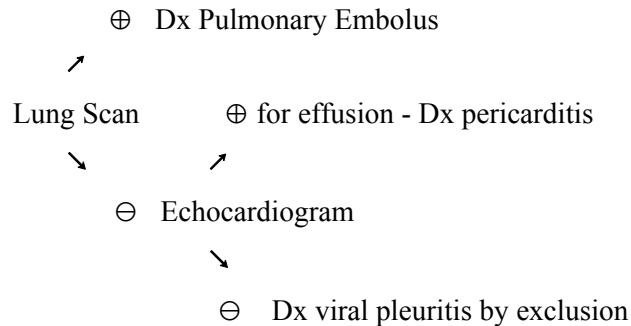
For each problem defined, a SOAP note must be recorded.

The **Subjective** and the **Objective** are each a brief review of the abnormalities identified in the history, physical, and initial lab data, which pertain to that particular problem. These need not be lengthy, but simply one or two lines reviewing the pertinent data.

The **Assessment** is a brief but pertinent paragraph describing what the physician thinks about that particular problem. If the problem recorded is a sign or symptom requiring a differential diagnosis, the DD must be recorded in a prioritized manner with a brief statement as to why the physician includes the differential that he or she does. If the problem is a known diagnosis (example - asthma), the physician must include in the Assessment a statement that describes the severity and why the problem has worsened requiring admission to the hospital.

The **Plan** must include three distinct groupings:

- A. **Diagnostic Plan:** The diagnostic plan includes all the diagnostic workup which the admitting physician feels will be necessary. If the Assessment includes the differential diagnosis, then each must be ruled in or ruled out in the diagnostic plan. This may be done by way of a Venn diagram. Consider a 23 year-old female admitted with pleuritic chest pain for which the admitting physician includes pulmonary embolus pericarditis, or viral pleuritis in the differential diagnosis. The diagnostic plan may be as follows:



If the problem is a known diagnosis, then the diagnostic plan must include additional work-up needed either to further define the problem or to assess the severity of the problem

- B. **Therapeutic Plan:** Must detail all initial therapies started and their rational.
- C. **Patient Education Plan:** Details the initiation of plans to educate the patient of what the problem is and how the patient will deal with it in the future.
4. **Daily Progress Notes:** Many physicians object to the POMR because its use results in lengthy, redundant progress notes. However, when used properly, the POMR does just the opposite and results in notes that are clear, direct, brief and complete. A few helpful hints regarding the progress notes are:
- A. A note for each active problem identified need not be written every day. If nothing has changed regarding a particular problem, a note for that problem need not be written. An observer will refer back to the prior day's note to get a progress report on that particular problem.

- B. The S, O, A, or P need not be rewritten if nothing is changed for that particular aspect of the problem.
 - C. A common error in writing daily progress notes concerns restating the problem under the Assessment in the daily note. Example: If the problem is congestive heart failure, the Assessment for that particular problem on any day cannot be “congestive heart failure.” This is simply a restatement of the problem. However, the physician must give a status report (example - better, worse, or etiology determined) under the assessment.
5. **Final Progress Note or Discharge Summary:** The final progress note should include all active problems, each defined as to its furthest resolution on the Problem List. The **S**ubjective should include a brief review of the course of symptoms. The **O**bjective should review the course of objective parameters. The **A**ssessment and **P**lan should include the probable course to follow and define end-points as a guide for further therapy. The emphasis on the final progress note should be the unresolved problems. Problems which are resolved can be written up briefly.