Medical Records and POMA
(the Problem-Oriented Medical Approach)

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Foundations for Medical Record Keeping: Compani

A series of self-study modules is available to assist veterinarians and clinic staff in understanding the requirem animal medical record keeping.

Review the Guide for a suggested self-directed learning plan to use the module series.

- Introduction to Medical Record Keeping *(10 mins)*
- Components of a Complete Medical Record *(60 mins)*
- Medical Record Maintenance and Security *(10 mins)*

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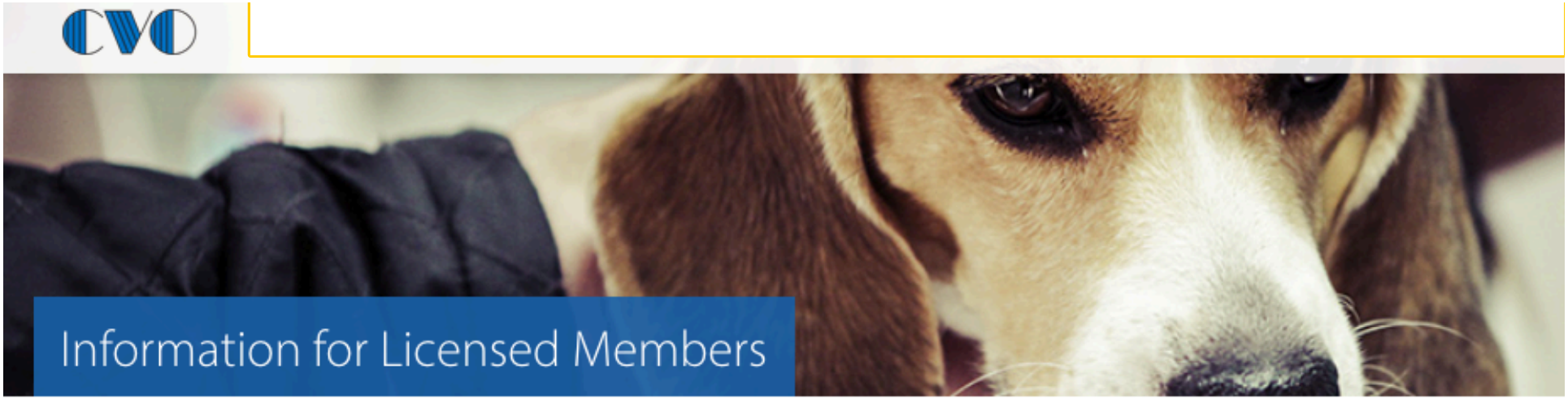

- Licensure
- Accreditation
- Professionalism in Advertising
- Who is in control of your controlled substances?
- **Quality Practice**
- Continuing Professional Development
- Learning Modules
- Peer Advisory Conversation
- Videos
- Medical Records Review and Assessment

For Licensed Members / Quality Practice / Learning Modules

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View these resources!!
They are on the quiz ☺

What is a Medical Record?

A legal document representing:

- Observations/Data
- Thought processes
- Decisions
- Actions
- Interactions with others
  - Clients
  - Colleagues, other caregivers
  - Specialists, laboratories

…each of which impacts on patient outcome.

What is a Medical Record?

It is a communication tool…

- Facilitating the continuity of care during case transfer from:
  - Veterinarian to owner
  - Veterinarian to other members of the veterinary team
  - Veterinarian to other veterinarians (referral)

It should enable seamless transition between caregivers without the need for verbal communication to have occurred

Required Components

- Owner identification (*Update regularly)
  - Name(s), address, telephone numbers, email
  - Name, address, telephone number, email of an alternate person to be contacted in case of an emergency ("agent")
  - This alternate contact may vary by context… always check!

- Patient identification
  - Animal name/identification, species, breed, colour/markings, and sex
  - Age (as date of birth)
  - Current body weight (or approximation)
  - Unique identifying patient number (ON EVERY PAGE)

- Date (every entry!)
- Author identification/signature (every entry!)

Required Components

- Content (every entry!):
  - **D**ata (**S**ubjective and **O**bjective)
  - **A**ssessment of the data
  - **P**lans resulting from the assessment

"DAP" or "SOAP"

"Data"

History

- Presenting complaint and progression
  - Prior diagnostic test results, treatments (&response)
- Other information:
  - Recent health
  - Current nutrition, lifestyle, intended use, etc
  - Current treatments, supplements, herbs
  - Prior medical issues
  - Preventative health (vaccines etc)

"Data"

Physical Examination:

- Need to report on ALL body systems
  - "Normal"
  - "Abnormal" (include details)
  - "Not evaluated"

- Templates help ensure everything gets checked and recorded

  "If you don't write it down, it didn't happen…"

"Assessment"

FIRST: <u>Identify the immediacy of the problem (triage)</u>

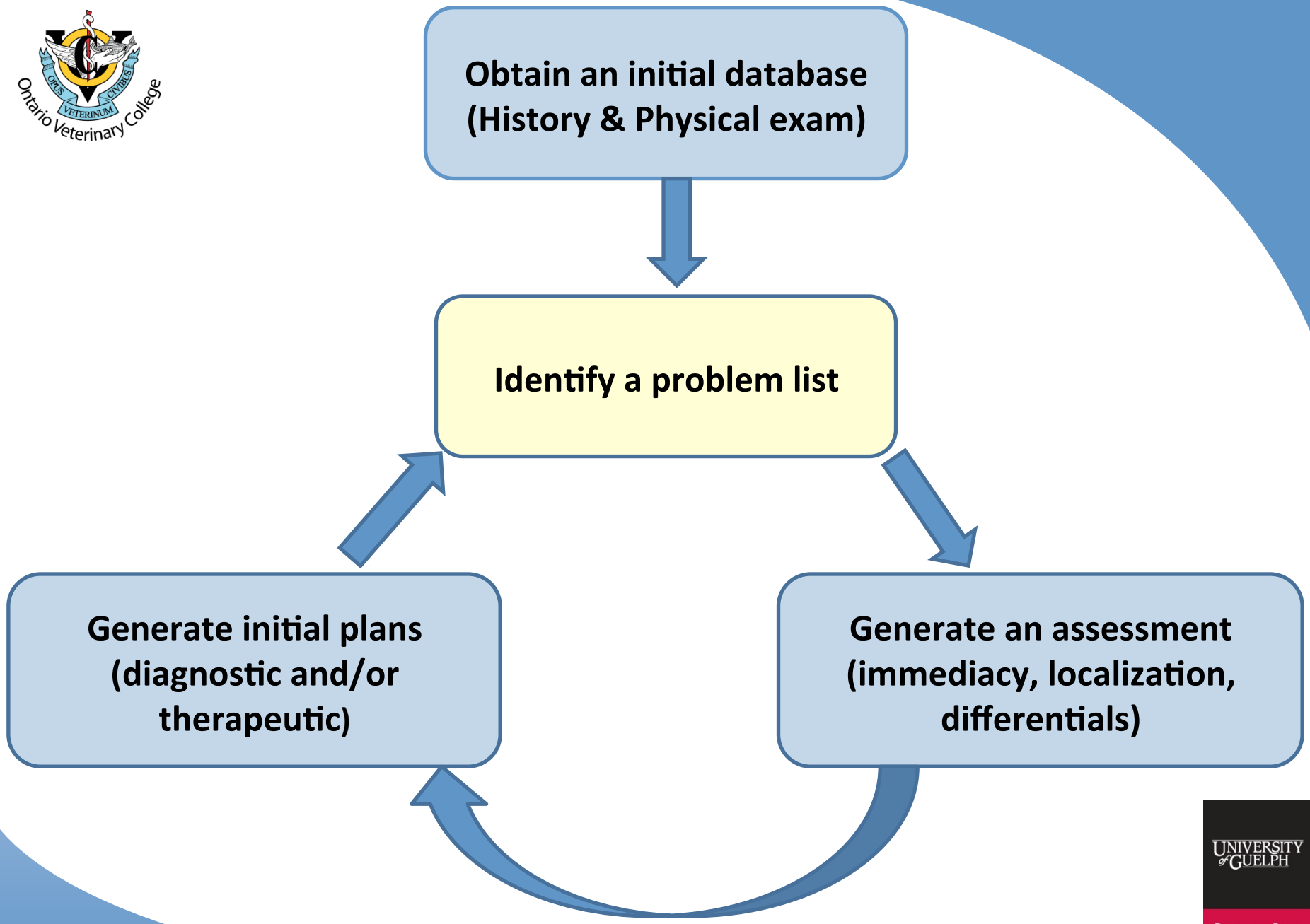
- State your initial thoughts on the case… assess the degree of URGENCY (and say what made you think this)

- What systems do you think need addressing?

"Assessment"

THEN: Problem List

- A list of all abnormalities from the history and physical examination (and any other tests if done)
- Several problems may be grouped <u>if</u>:
  - Logically related
  - None could possibly be from another reason
  - eg. Prolonged CRT
    Tacky mucous membranes
    } dehydration


Obtain an initial database (History & Physical exam)
Identify a problem list
Generate an assessment (immediacy, localization, differentials)
Generate initial plans (diagnostic and/or therapeutic)

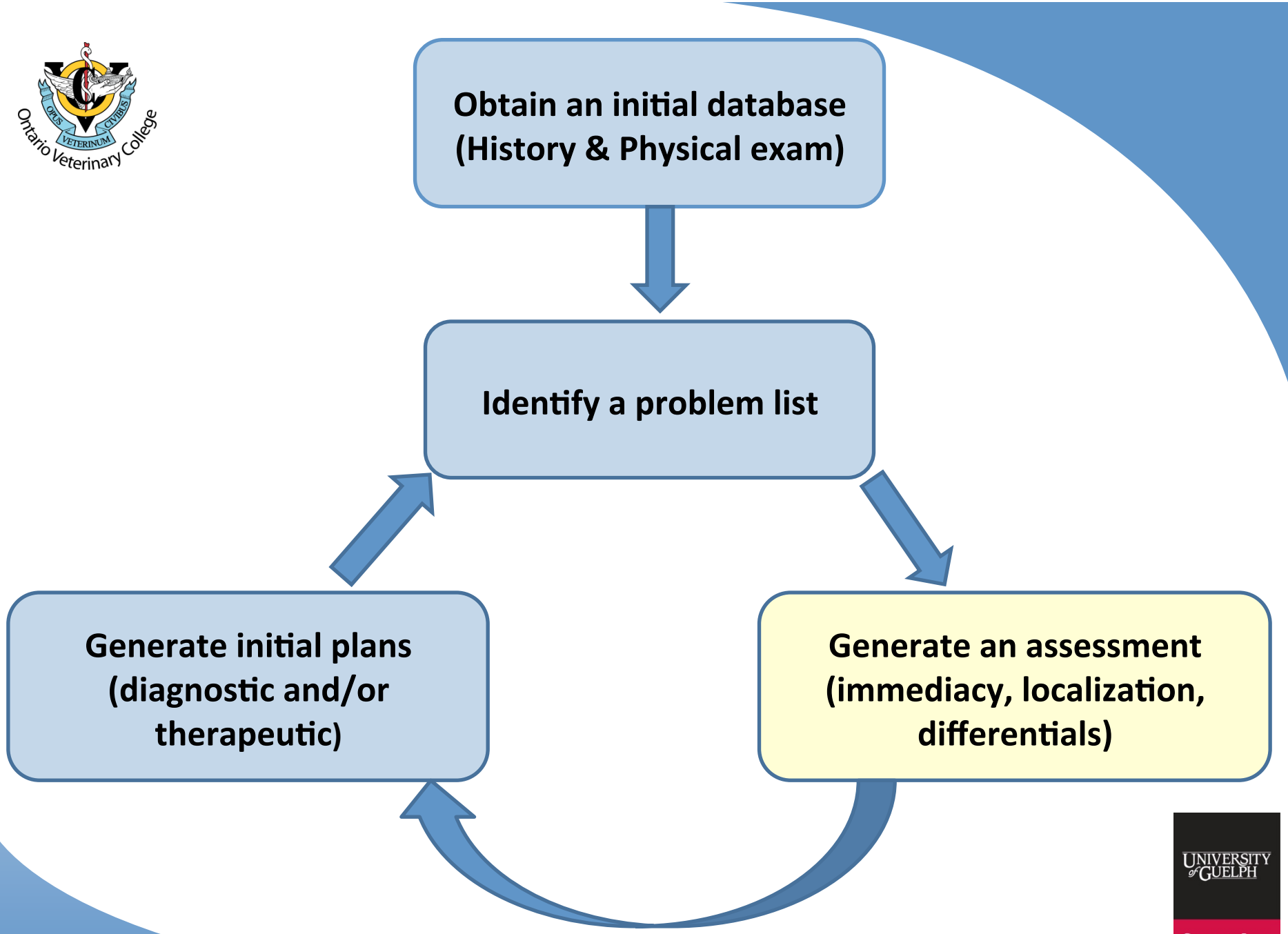
"Assessment"

Each Problem (or group of problems) is then dissected:

- Which body system(s) are involved
- Include a list of potential differential diagnoses (DDx)
- DDx are ranked in terms of likelihood (and discuss the reasoning behind your ranking)
- Tests are discussed that could help rule-in or -out one or more of the DDx
- Concerns are discussed (ie. anticipated complications)

"Assessment"

- A reader should be able to tell what you are **THINKING** about the case
- A reader should be able to predict your "Diagnostic and Treatment Plans" section based on the assessment
- A reader should also be able to know what to watch for (case progression, complications…)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"Plans"

Diagnostic Plans

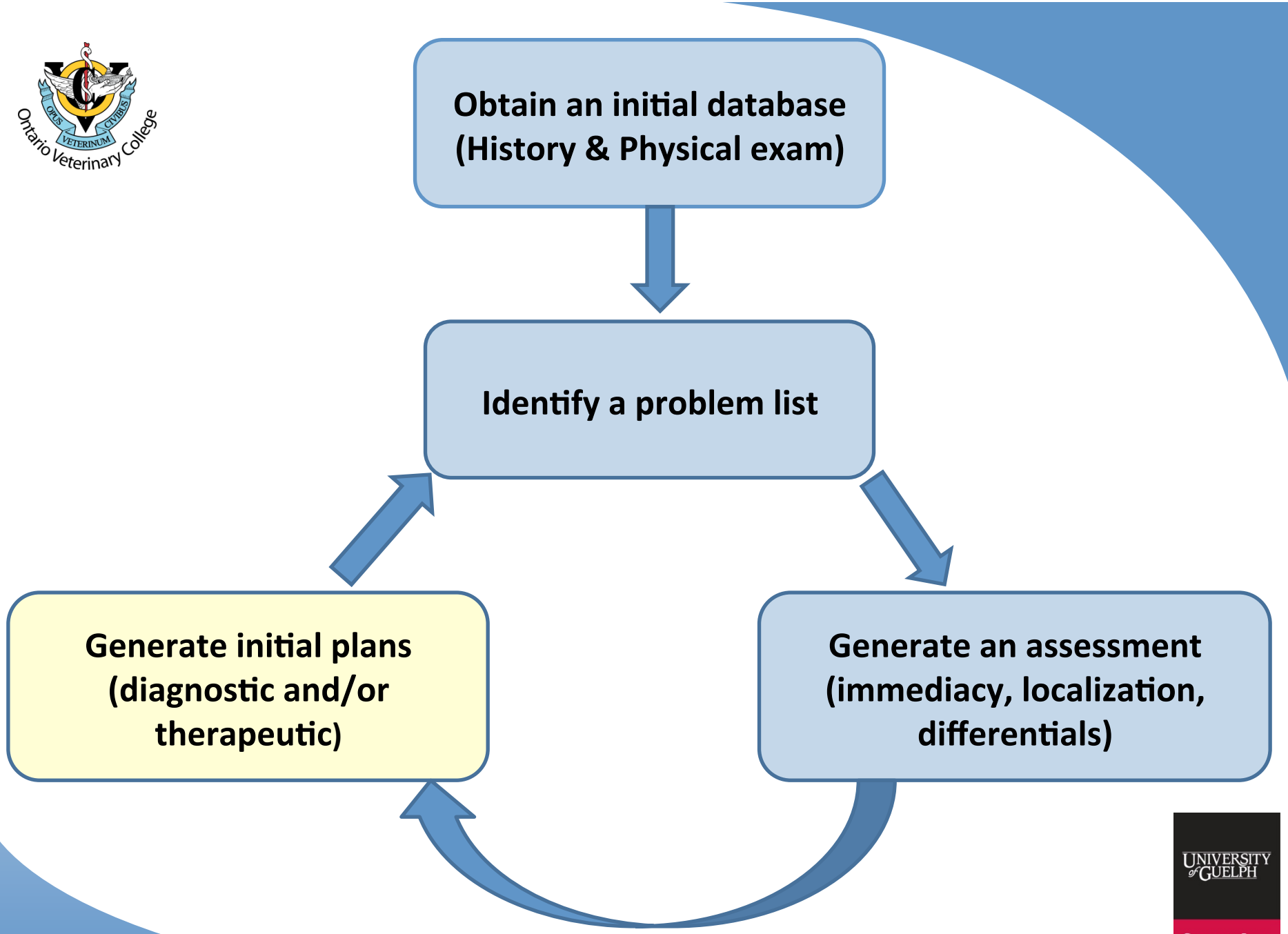
- Checklist of tests you plan to perform

Treatment Plans

- Specific details (drug, strength, dose, volume/ quantity, route, frequency, duration…)

Client Communication Plans

- Topics that need to be discussed with the client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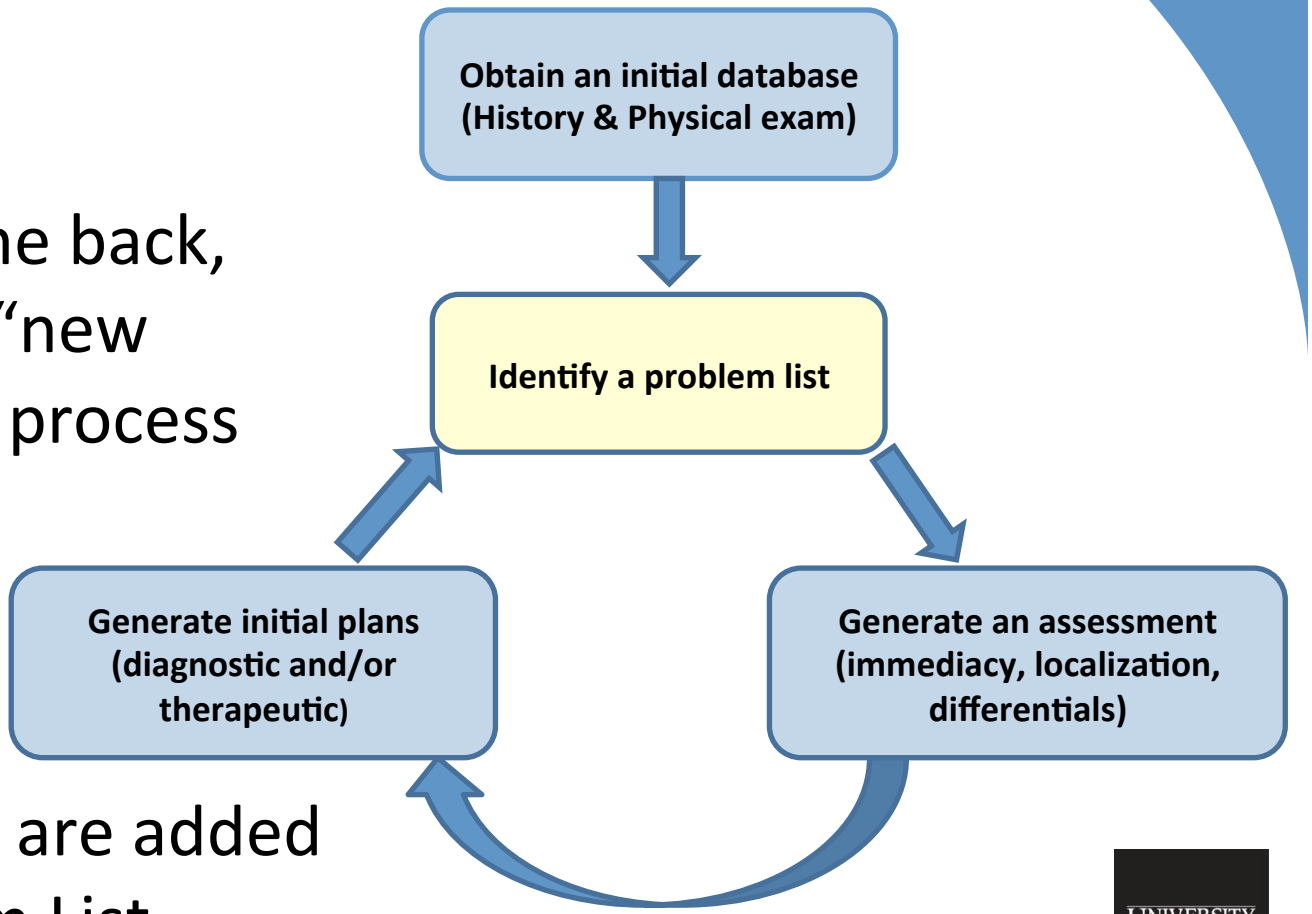
What next?

- As results come back, they become “new data” and the process begins again…

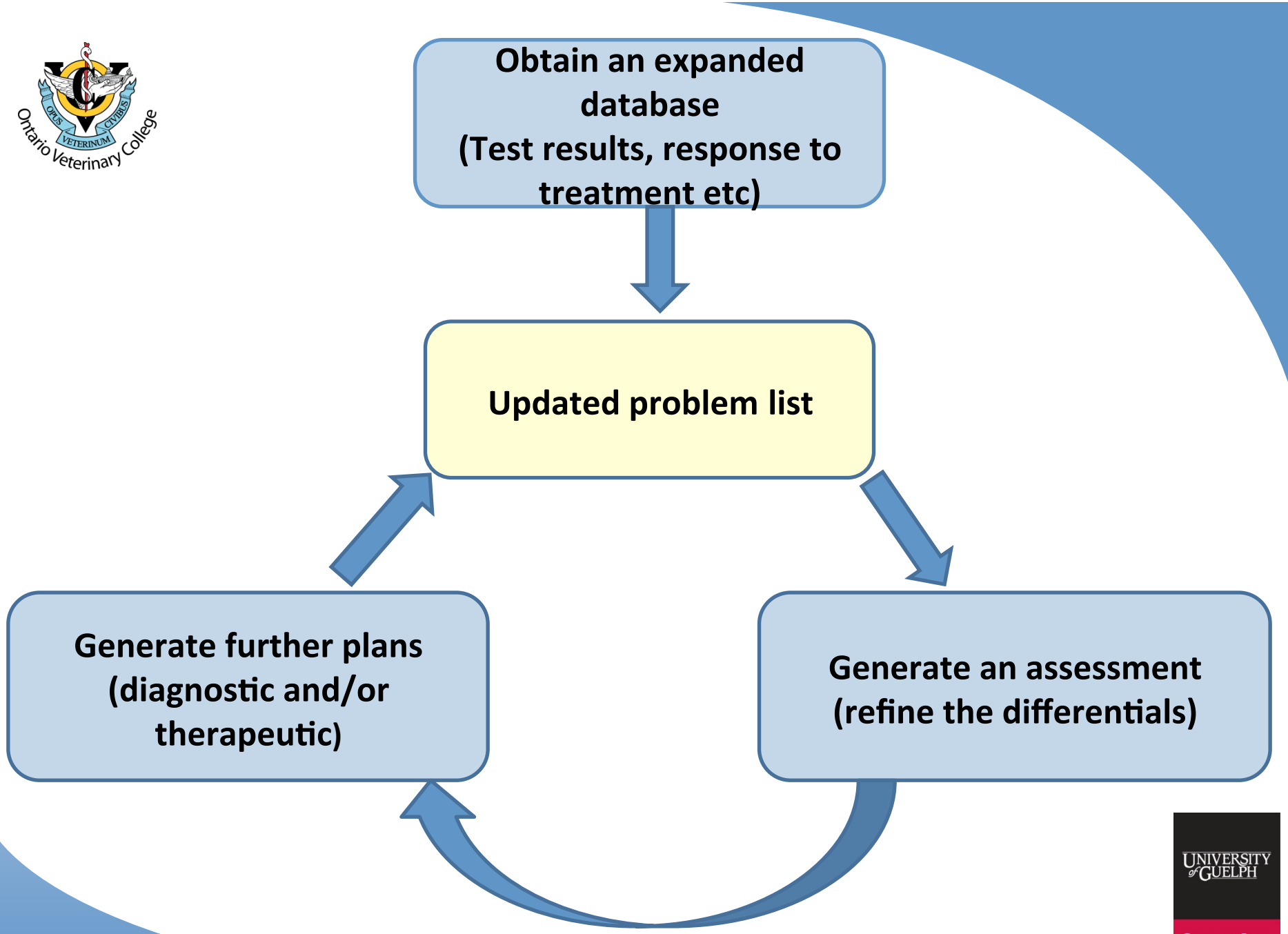


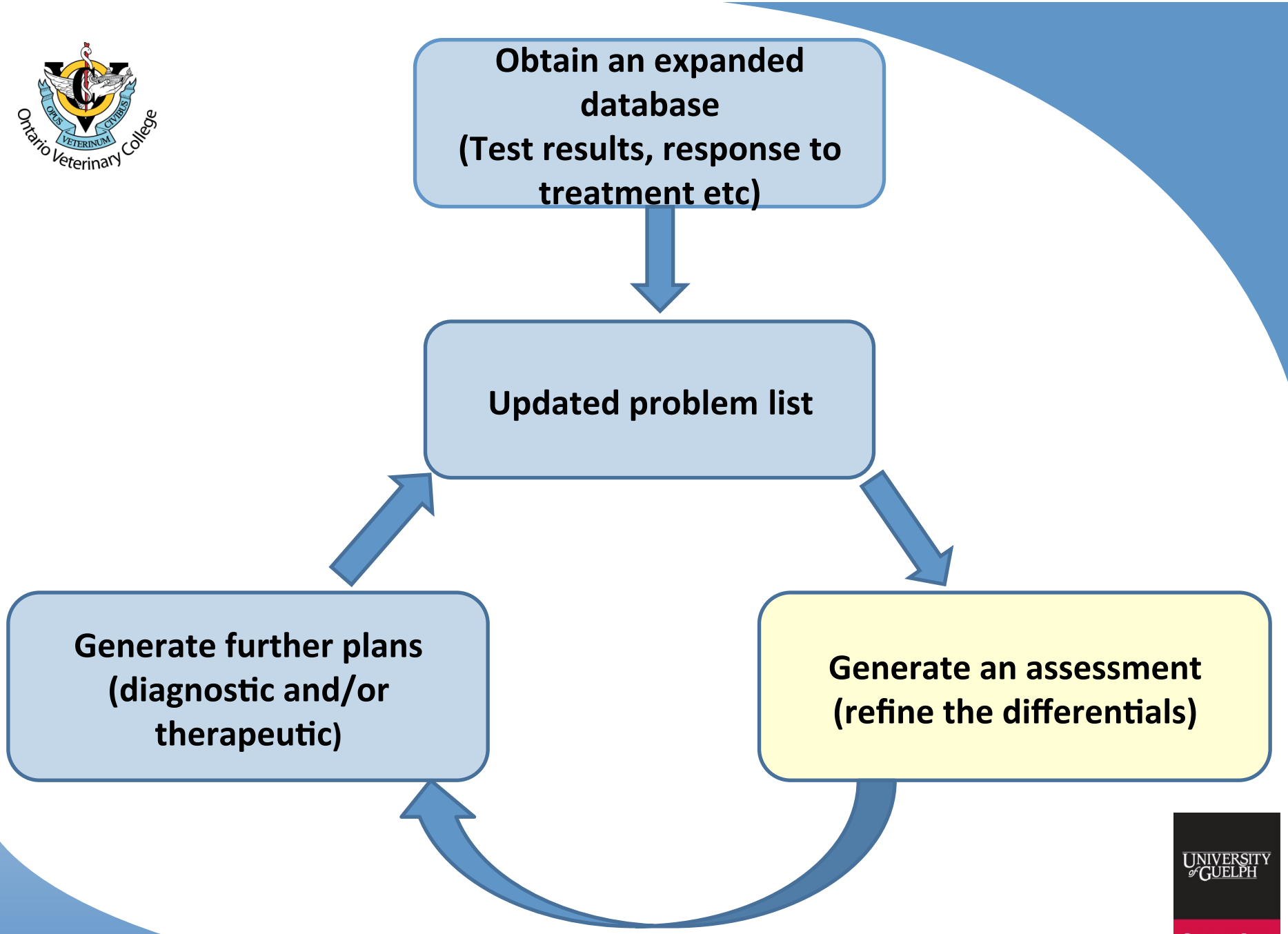
- Abnormalities are added to the Problem List

"Addendum"

- An update on the case within the same day, reflecting new understanding about the case *(from test results, response to initial therapy, etc)* presented as a new DAP/SOAP entry with a new date/time:

  - **D**ata (**S**ubjective and **O**bjective) – new results, update on case status etc.
  - **A**ssessment of the new data; updated diagnosis, new concerns etc.
  - **P**lans resulting from the assessment


Obtain an expanded database (Test results, response to treatment etc)
Updated problem list
Generate an assessment (refine the differentials)
Generate further plans (diagnostic and/or therapeutic)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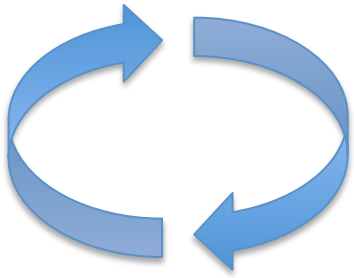
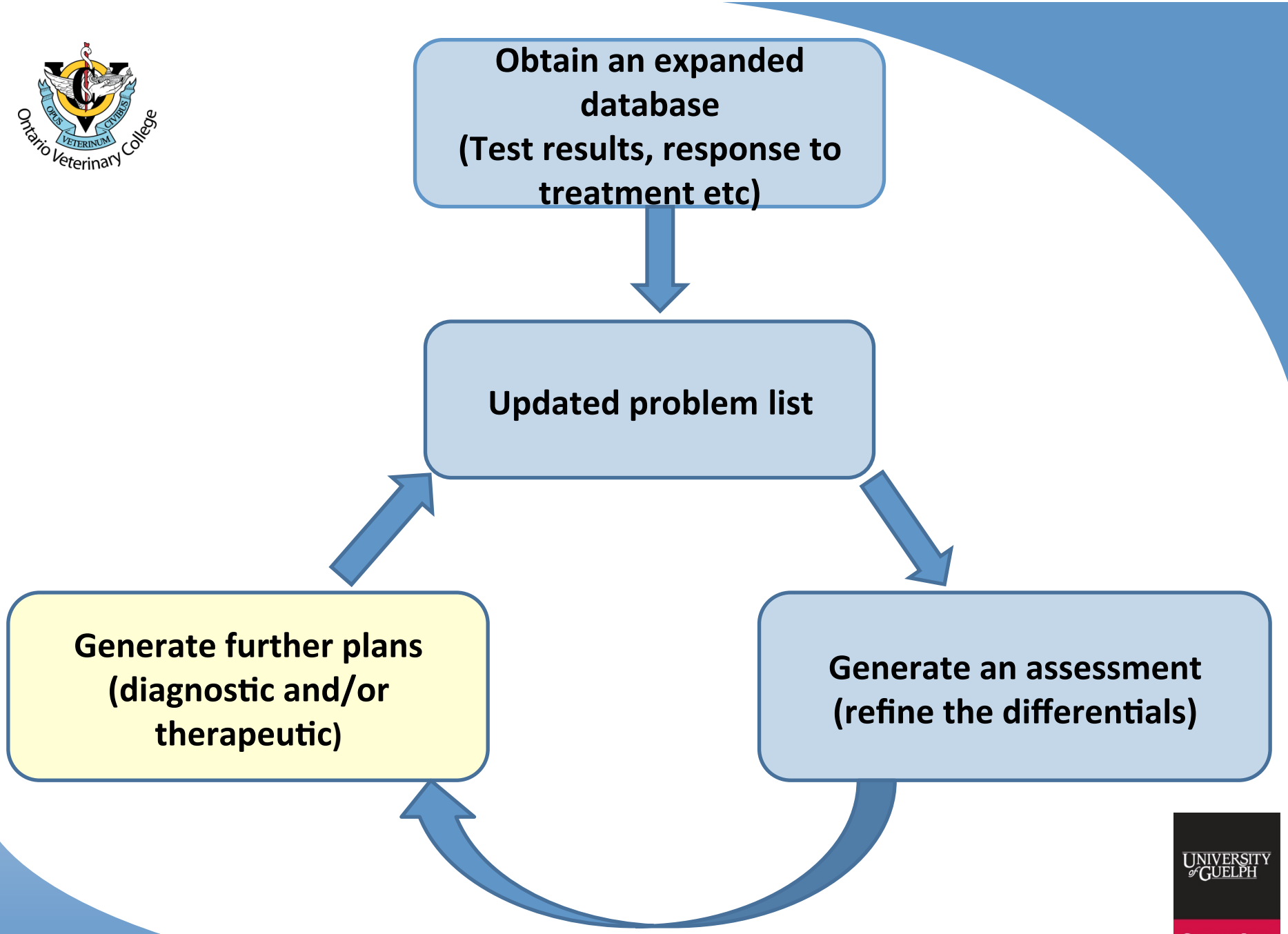
- New Assessment:
  - Based on this new information, what are you thinking about the case **NOW?**...
  - A new assessment is generated that shows your "thinking in the moment"
  - New diagnostic and treatment plans are generated

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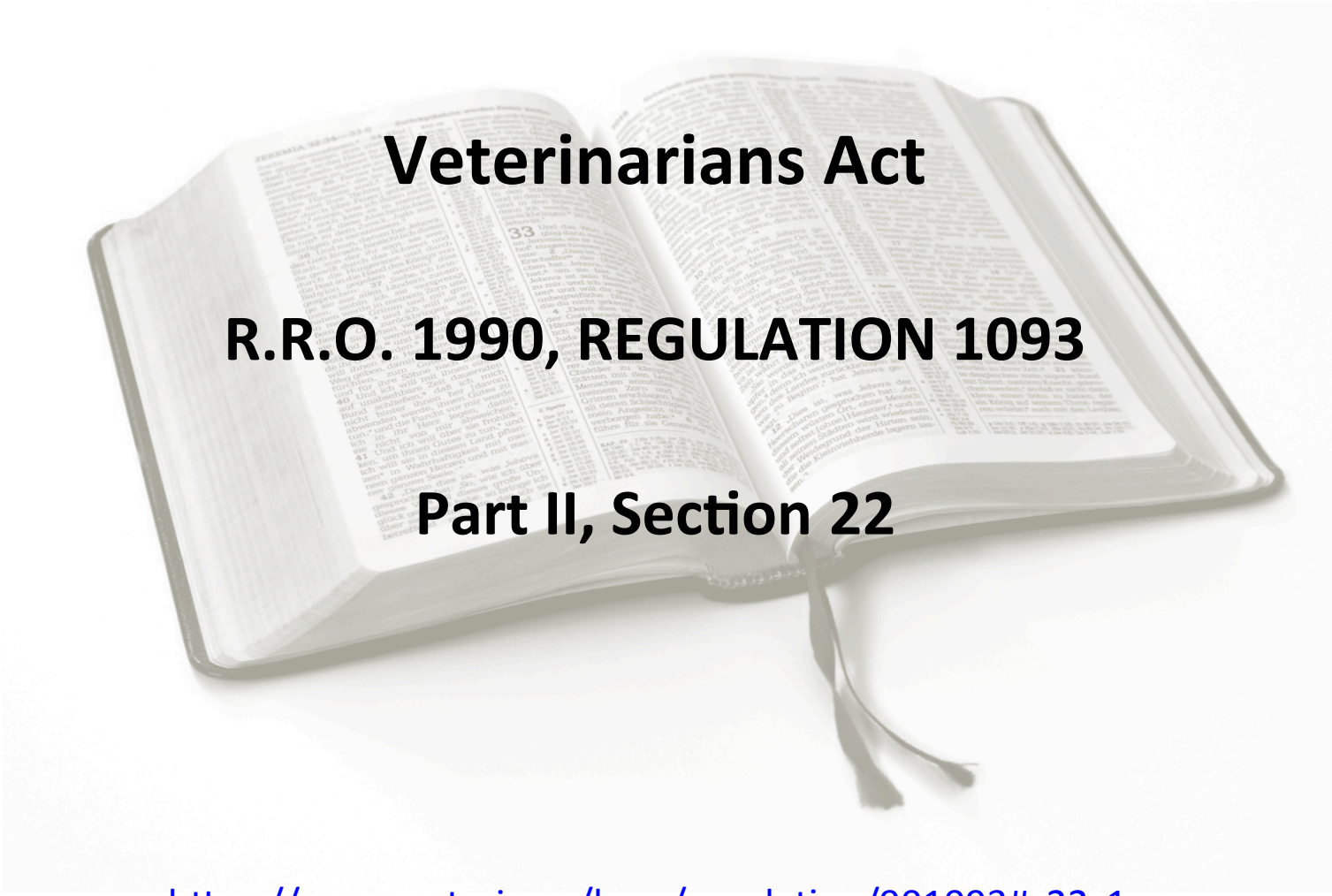
- **<u>Master Problem List</u>**: *(lives at the front of the file)*
  - A living document
  - Reflects ALL problems over time
  - Reflects which problems are still active
  - Can also be used to reflect anything you want to remember about the case as you make decisions!
    - Pregnancy
    - Drug allergies
    - Recent risk factors, etc.

The Actual Rules…



Veterinarians Act

R.R.O. 1990, REGULATION 1093

Part II, Section 22

https://www.ontario.ca/laws/regulation/901093#s22s1

Legislation

Requirements of a Veterinary Medical Record:

- Legibly written (or typed)
- All components are present
- Abbreviations are only commonly-used ones (maintain an abbreviation key in the clinic)
- Kept in a systematic manner
- Retrievable using patient unique identifier

Legislation

When a change to the record is required:

- Audit trail is established
- Original content is preserved
- Reason for change is indicated
- Date/time of change is indicated
- The person making the change is recorded

- “Treated with 1.1mg/kg = 10ml of flunixin IV”

0.5mg/kg = 5ml (entry error, JHewson, Feb 7/19, 3:45pm)

- “Treated with ^~~1.1mg/kg = 10ml~~ of flunixin IV”

- “Treated with 1.1mg/kg = 10ml of flunixin IV”

  “Correction: Entry error. Actual treatment was with 0.5mg/kg = 5ml of flunixin IV. JHewson, Feb 7/19, 3:45pm.”

Legislation

- Maintain records in a secure manner to protect client confidentiality
- Timeliness of providing medical information to facilitate continuity of patient care
- Maintain records for 5 years from the last entry *(or 2 years from ceasing veterinary practice)*
    - Safeguard against loss, damage
    - Destroys records such that client confidentiality is maintained