The Introduction of a Patient-Retained Problem-Orientated Medical Record (POMR): A preliminary report

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Summary

The motivation for planning, structuring and implementation of, a Patient-Retained Problem-Orientated Medical Record (POMR) is briefly discussed with reference to the literature.

KEYWORDS: Medical Records, Problem Oriented; Medical Records Department, Hospital; Patient Participation; Physicians, Family.

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Curriculum Vitae

Hendrik Johannes van der Westhuizen is vanaf 1 Maart 1984 in die Departement Huisartskunde te MEDUNSA aangestel en is tans mede-Professor daar. Hy het in 1955 op Brits gematrikuleer en is daarna na die Universiteit van Pretoria waar hy die MBChB verwerf in 1962. Vanaf 1969 tot 1973 was hy deeltyds lektor in die Departement Huisartskunde te UP. In dié tyd was hy ook behulpsaam by die studente se Polikliniek te Daspoort. In 1973 verwerf hy ook die MFAP van die Kollege van Geneeskunde van SA. Hierna het hy 'n jaar as senior mediese beampte te Ga-Rankuwa-hospitaal gewerk. Sedert 1974 is Dr Hein (soos hy bekend is) huisarts op Brits waar hy baie betrokke was by verskeie gemeenskapsdienste. Hy stel intens belang in geneeskunde en die bevordering van Huisartskunde as 'n beroep.

OUR LOCAL EXPERIENCE

TWO of the authors had had positive experiences with patient-retained records before joining the Dept of Family Practice at Medunsa. At Ga-Rankuwa Hospital, where our teaching practice is located, we encountered some serious problems that encouraged us to look at the possibility of introducing patient-retained records to our area.

The first major problem encountered with the hospital record system was that 7% of all medical records were unavailable when patients attended our practice. Another problem was that registering of patients and searching for files could sometimes take up to 4 hours — resulting in a patient arriving at our practice at around noon after having reported to the hospital at 08h00. At a clinic associated with the hospital, it was found that 5% of all records were not available, whilst the same delays were experienced with registering patients and obtaining files. Clinics controlled by Brits Municipality reported that 4% of whites attending the clinics did not have their cards, whilst amongst the blacks the figure was 5%. At a Bophuthatswana clinic, 6,4% of all records were unavailable. An interesting finding here was that there was an equal distribution of fault between the clinic and the patients: *ie* equal number of misfiled records and lost cards. It was thus apparent that patients could look after their own records as well as, if not better than, hospital and clinic administrations.

LITERATURE REVIEW

Morley[1] reports that 95% of patient-retained records were available in a survey he conducted. "Mothers regarded the card as a sort of passport to health care and were proud to possess it. Mothers were sometimes found in tears in the clinic waiting room because someone had picked up their 'Road to Health' card — and they thought it was lost."

Germond joined our department with 12 years experience of patient-retained records, gained whilst working at Scott Hospital in Lesotho. Due to lack of funds, a hospital record system was not possible and in order to implement some degree of continuity of care, patients were given their treatment sheets to keep. It was found after a time that patients were returning to the hospital with piles of these sheets and this encouraged the hospital to introduce a very simple, blank-paged patient-retained medical record, which is still in use today. The people of this area have a poor regard of primary health care workers, who do not write in their books. (T Germond: Personal communication).

Morley[2] is of the opinion that a patient-retained record places greater responsibility on the parent for the care of the child, and thus greater emphasis can be placed on the most important source of care — that within the home.

This observation is in line with the approach of the Royal College of General Practitioners[3] whose policy is that every child should receive "a comprehensive, curative and preventative service — including health surveillance — through general practice."

A patient-retained record is a helpful reminder to share care with the patient. Petrie[4] states that "doctors and other health personnel should be the prime movers in bringing about a change of attitude and practice. Shared and collaborative care are the key concepts in obtaining more power and responsibility."

Eugene J Stein[5] reports on studies conducted with psychiatric patients who were given the option of having a copy of their reports. Most patients felt that it was a good system. "Even though patients were sometimes upset by what they read, they were generally comfortable with reading their records and felt better informed and more involved in their treatment. The staff felt that the patients' access to their medical records was therapeutic. They tended to omit certain details from the record but also became more accurate and thoughtful about what they wrote. The patients had a chance to correct inaccuracies. All three studies suggested positive benefits — including enhanced patients' rights, improved treatment and improved patient-staff relationships."

It was found that patients look after their records just as well as official administrators.

Laforet[6] concluded that a personal, portable, continuing health record is an adjunct to superior medical care in a complex and mobile modern society and that the medical profession should encourage and facilitate its voluntary adoption by patients.

Stott's[7] experience is that even illiterate tribal mothers prove remarkably able in the use of self-held records.

The legal aspects of confidentiality and privacy[8] must be borne in mind. If the key concept that privacy is a fundamental aspect of law and medicine is kept in mind, this potential hazard should not pose major problems.

The patient-retained record is a powerful tool in research. Morley[2] found that a high percentage of both boys and girls in his village attended the clinic regularly enough for their weights to be charted in most months of the year. The charts were also used to assess how frequently the children attended clinic. Cognisance should be taken of the fact that if records are kept at the hospital, they are only available when the patients attend the hospital or clinic without an up-to-date register. Patient-retained records on the other hand are always readily available for research purposes in a household survey.

FURTHER MOTIVATION AND RECORD DESIGN

The cost-effectiveness of patient-retained records is indisputable when one considers that less delays are experienced by patients and no filing clerks or record rooms are paid for in a totally patient-retained record system.

The Introduction of a Patient-Retained POMR

In our area the episodic care of black patients who shop around between private family practitioners, clinics and hospitals involved in primary care, makes record-keeping a major problem — so much so that many private practitioners keep no records of patients they do not expect to see again. This leaves the patient with no knowledge or record of his diagnosis and treatment — and consequently with no bargaining power. This leads to the perpetuation of episodic care.

Another aggravating factor in this process is the inadequate referral system existing between the parties concerned.

It is our belief that the patient-retained record system will go far in eliminating episodic care and greatly enhance continuity of care for our patients — thus providing a better health care service.[2]

Our prime targets were the Tswana- and Zulu- speaking people of our practice.

Firstly, we deciced to use an A6 format which would fit easily into a pocket. Another reason for this decision was that plastic bags were already available on the market which could hold the A6 format. (Fig. 1).

The outside cover of the booklet consists of a durable film-centred board, divided into three sections. The middle section is the front page, whilst the first section folds back to contain a flow chart for immunisation. The third section, both sides, contains health education. (Fig 1)

Fig 1.

The first inner section is for the problem list and health promotion. The inner middle section which continues onto the next page, consists of a growth chart and shows milestones for normal development (Fig. 2 & 3). The rest of the pages are for progress notes or flow charts, if necessary.
With the record open, the problem list and health promotion page is always visible. (Fig 3 & 4).

Throughout the planning and structuring of the record, we kept the 'kiss' principle in mind. (Keep it Simple, Stupid)

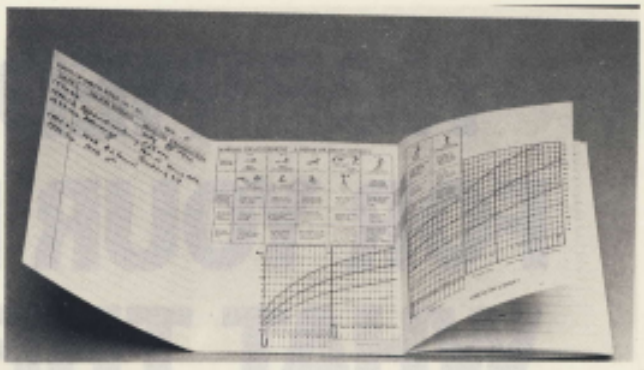

Fig 2.

Patients feel more involved in their treatment if they carry their own record.

Fig 3.

Staff felt that patients' access to their medical records was therapeutic.

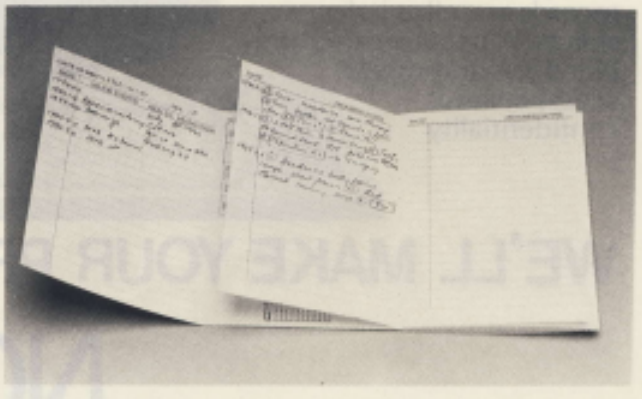

Fig 4.

The factory health service where the study population is employed, has met most of the requirements for screening programmes. Apart from hypertension, diabetes mellitus and tuberculosis are constantly screened for; the latter because of statutory requirements, rendering the extra cost involved in screening for the other two problems, as far as testing equipment and manpower is concerned, negligible. Any cases with positive results are then effectively followed up and treated, as already described, on the premises. The health service is expanding all the time, also diagnosing and treating sexually transmitted diseases and rendering family planning services on the spot. The aim is to cover the whole sphere of health practice eventually[13].

Conducting this study has led to an established hypertension clinic for the whole work force, with blood pressure charts being kept on which readings by date, medication and blood pressure reduction and maintenance targets according to the ideals for different age groups, are recorded[2] (Fig 2).

Time is spent interviewing the individual to obtain more personal information as regards the multitude of contributory factors associated with hypertension as quoted by Seedat[8]. More time is also spent on patient education with regard to associated problems, eg obesity, sodium intake and tobacco smoking.

CONCLUSION

I have been amazed to see how such a project has stimulated all members of the health team to be on the alert, to think and to search. I am now convinced that all of us general practitioners can play an important part in regular research work.

The pilot findings on differences in the prevalence of hypertension between ethnic groups will be followed up.

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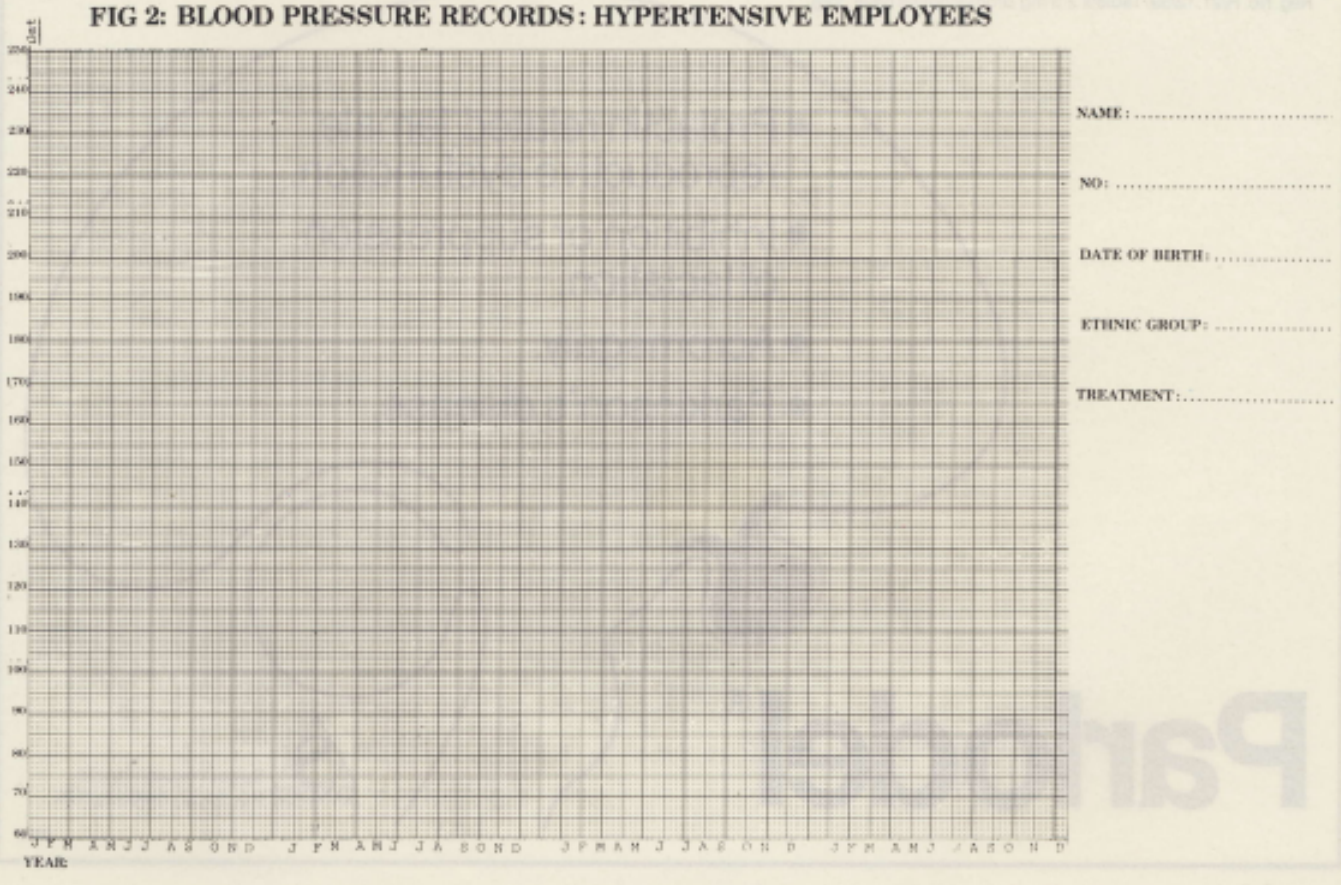
FIG 2: BLOOD PRESSURE RECORDS: HYPERTENSIVE EMPLOYEES



IMPLEMENTING THE RECORD

We motivated our own department to introduce the record to the patients visiting the practice. The nursing staff were also motivated personally by the doctors working with them.

The Department of Paediatrics at Ga-Rankuwa Hospital were also involved. They have undertaken to issue the record to all newborns in the hospital, especially those who become patients.

All the general practitioners in our area were invited to have some input into the implementing of the record.

Industry was informed through the Chamber of Commerce of Rosslyn and Brits. Here the records were enthusiastically received. Some companies have already introduced the record to their employees.

When visiting clinics in our area, we explain the value of the record to the sisters and patients.

CONCLUSION

We feel that medical records must be available and have thus started to implement this patient-retained problem-orientated medical record. We hope to study its influence and to see if continuity of care, communication between different parts of the health service and patients' participation in their own health care, will improve.

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