Documentation and Medical Records
Paper-based and Computer-based

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Brainstorming

Talk in groups two and two.

Questions:
- What is medical documentation and a medical record?
- Why is it important with medical documentation?
- Who is documenting?
After Today...

• You will know what a care process is
  – Example from primary health care and hospitals (wards)

• You will know more about medical records
  – What it looks like
  – Who is documenting
  – What kind of information it contains
  – How it can be structured

• You will understand some problems with paper-based and computer-based medical records
The Generic Care Process

- The patients way through healthcare, from sick to healthy.
Medical Documentation

• Important part of the care process

• In the medical record

• Relevant fact, findings and observations about an individual's health history including
  – past and present illnesses
  – examinations
  – tests
  – treatments
  – outcomes
The Care Process in Primary Health Care (swe. Primärvård at Vårdbcentral)

The patient has a problem 😞

Calls primary health care, to get advice from eg. a nurse

Meets physician

Examination and initial diagnosis

The patient is healthy 😊

Referral to specialty care, or treatment at primary health care

Decision about treatment, start the treatment
Doctors vs. Nurses

• Doctors **diagnos and treat** patients

• Nurses give **care** to patients

  "Nurses care for the sick and injured in hospitals"

• When a person becomes ill or is injured, generally the doctor assesses the patient, diagnoses the patient's problem and decides on the treatment needed to cure the problem or relieve the patient's symptoms.

• Today, however, nurses play a large role in evaluating patients and detecting problems. In some rural areas, nurses admit patients to hospital and manage their care, referring only the most critical patients to distant medical centres.
Hospital (Specialty care)

Registration process

• Patient information – administrative and clinical data
• Initial examination – anamnesis* and clinical examination
• Decision on care commitment; is the patient at the right care unit?

Diagnostic process

• Actions: tests and examinations
• Make a diagnosis
• Decision about treatment / therapy

The medical history or anamnesis of a patient is information gained by a physician by asking specific questions, either of the patient or of other people who know the person and can give suitable information.
Hospital

Treatment / therapy

- Treatment / therapy plan
- Treatment / therapy actions
- Result?

Discharge process

- **Epicrisis;** a critical or analytical summing up of a medical case history
- **Prognosis;** the prospect of recovery as anticipated from the usual course of disease or peculiarities of the case
- Re-use documented data
- Follow-up
A Patient’s Clinical Picture

Health issues

Contacts

Direkt pat.kontakt
Indirekt pat. kontakt
Direkt pat.kontakt
Direkt pat.kontakt
Indirekt pat. kontakt
Direkt pat.kontakt

Diabetes
Kontroll av lab. resultat
Diabetes
Kontroll av lab. resultat
Diabetes

Högt blodtryck
Högt blodtryck
Högt blodtryck

blir kontr.
-blir kontr.
-blir kontr.

-recept
-recept
-recept

Kalendertid

Time
What is a Medical Record?

- A Medical or Patient record is a systematic documentation of a patient's medical history and care.
- It contains various categories:
  - Administrative data
  - Anamnesis
  - Status
  - Diagnostic actions
  - Test result, x-ray
  - Diagnosis
  - Therapy plan (treatment)
Goal with Medical Records

• Collect relevant data for supporting
  – Treatment
  – Decision making
  – Evaluation
  – Quality making
  – Research
  – Education

• Better quality of the care process

• Give the patient the best care possible
Legally Required to Document

- Physicians – in the medical record
- Nurses – nursing documentation
- Allied Health Personnel
  - Psychologist
  - Physiotherapist
  - Welfare officer
VIPS – Documentation Aid For Nurses

- Tool / model for a high quality and secure nursing documentation
- Documentation to support caring
Structure of Medical Records

Time Oriented
Structure of patient records

- Time Oriented
- Problem Oriented
Problem Oriented Medical Record (POMR)

- Subjective
- Objective
- Assessment
- Plan
Structure of Medical Records

- Time Oriented
- Problem Oriented
- Source Oriented
Diagnos: K358
Akut appendicit, specificerad

Operationskod: JEA00
Appendektomi

Smf sjukhistoria:
Tidigare frisk man inkommer akut med buksmärtor sedan 1 vecka som accentuerats. Utvecklat tecken på appendicit. Sedvanlig appendektomi utförs som visar mycket ful appendix, till PAD. Lätt afebril efter förloppet.

Bedömning: avvaktar PAD

Recept:
-

Sjukskrivning: Sjukskrives 1 vecka

Återbesök: Ja,
10/3 hos distriktsköterska (2008-03-05 15:54:28)

Omvårdnadsdiagnos: Huvudaktivitet
Paper-based Medical Record

Negative

- One place at a time
- Missing records
- Unstructured
- Hard to read
- Hard to get a good overview
- Many different records
- Quality assurance is difficult
- Hard to archive
Hard to archive...
Electronic Medical Record (EMR)

Often used in primary health care, less used at hospitals

- Access to all information
- Easier to make a clinical picture
- Don’t need to search for the record
- The patient don’t have to explain everything every time
- Reuse test result
- The same structure for all documentation
Not So Great With EMR

- Low usability, major problem!
- The computer/network is not working (downtime)
- Slow computer programs (response times etc)
- Same structure for all care providers (kind of enterprise system)
- Bad authorization systems (no single-sign-on)
- Not one patient one record (often not the case)
Patient Data Act
(swe. Patientdatalagen)

• The purpose of the Patient Data Act is to improve patient security and protect sensitive data.

• Requirements on
  – Security
  – Documentation
  – Rules for secrecy and accessibility

• All care providers (are legally responsible to follow the patient Data Act)
EMR Systems

• Multiple systems for primary care

• 5 dominant systems for the whole care process in Sweden:
  – TakeCare (Profdoc)
  – Cambio Cosmic (Cambio)
  – Melior (Siemens)
  – VAS (Norrbottens läns landsting)
  – Systeam Cross
Number of users ~market shares

Marknaden för vårddokumentationssystem
Sjukhus, psykiatri och primärvård
Antal användare 2013

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<th>Service</th>
<th>Primary health care</th>
<th>Hospital care</th>
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<td>PMO/J3 (4,2%)</td>
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<td>VAS (7,7%)</td>
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<tr>
<td>Systeam Cross (10,4%)</td>
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<td>Take Care (20,6%)</td>
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<tr>
<td>Melior (25,9%)</td>
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<tr>
<td>Cosmic (27,6 %)</td>
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</tbody>
</table>

Antal användare
Sjukhus/psykiatri = 186.527
P-vård = 37.021
Totalt = 223.548
Varav 6.245 privat

eHälsa i landstingen 2013, Lars Jerlval och Thomas Pehrsson
Example: Cambio COSMIC

Concept: One patient – One medical record

• Clinical care support
  – Care documentation
  – Order management (e.g. radiology, lab, consultations....)
  – E-prescription
  – Birth, Craft (surgery), Emergency, Link

• Patient administration system (PAS)
  – Resource planning
  – Patient management
Example Screen: Select Patient
Read Records, Reference
Write Records
Patients At A Care Unit, Ward
Summary

• The patients’ way through the health care is called care process

• A medical record is a systematic documentation of a patient's medical history and care

• Physician, nurse, psychologist, physiotherapist, welfare officer are legally required to document

• The medical record can be time-, problem- or source-oriented

• Patient Data Act: improve patient security and protect sensitive data
Thank You For Cooperating!

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