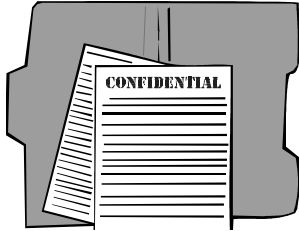


DOCUMENTATION

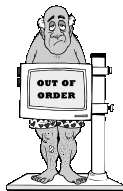


The medical record is...

- A legal document
- The information in the record is owned by the patient
- The facility owns the record itself
- Always use approved abbreviations
- Use black ink
- Use legal method for correcting errors

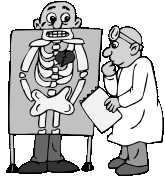
Subjective Data

- What patient experiences
- Symptoms only the patient is aware of:
 - nausea
 - pain
 - weakness



Objective Data

- Signs
- What can be seen, palpated, sensed by the observer
 - cyanosis
 - bruises
 - height
 - weight
 - vital signs
 - diagnostic reports



Problem Oriented Medical Record - POMR

- Database:
 - Hx, PE, subjective & objective findings
- Problem list:
 - physical, psychosocial, economical, occupational, plan of care
 - each problem is given a number
- Plan:
 - diagnostic tests, Tx, patient education

SOAP



- **S** subjective - what the patient feels
- **O** objective - examiner observations, measurements, PE, diagnostic findings - lab reports, radiological reports
- **A** assessment or analysis of subjective & objective = diagnosis
- **P** plan, what will be done

Source-Oriented Medical Record - SOMR

- Narrative - long, wordy, difficult to find information
- Chronological
- Reverse chronological



Let's practice correcting documentation errors...

- Never erase
- Never obliterate - write over or scribble over
- Use a single line through error
- Date, time, & initial
- Enter correct information following facility policy