FORMAT PENDOKUMENTASIAN REKAM MEDIS (*PAPER BASED*)

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JENIS FORMAT DRM

1. *Source Oriented Health Record* (SOHR)
2. *Problem Oriented Health Record* (POHR)
3. *Integrated Health Record* (IHR)

SOURCE-ORIENTED HEALTH RECORD

- Lihat pada hlm.303 buku Documentation Health Records

Source-Oriented Health Records

In the **source-oriented health record**, documents are grouped according to their point of origin. That is, laboratory records are grouped together, radiology records are grouped together, clinical notes are grouped together, and so on. Thus, physicians' progress notes for a single episode of patient care are arranged, usually in reverse chronological order, and filed together in the patient's health record. Similarly, notes prepared by nursing services, social services, and other clinical services are grouped according to service and arranged sequentially.

Under this format, the individuals charged with filing reports in paper-based records can do so simply by looking at the source and date of the report. However, the users of information filed in this type of record have more trouble. To follow or document information on the patient's course of treatment, they must search by date of occurrence in each of the sections (that is, laboratory, radiology, and every group of clinical notes). The more departments a hospital has, the more sections the source-oriented health record can have. The end user must tie together information from the various sections of the record to get a full picture of the patient's course of treatment.

PROBLEM-ORIENTED HEALTH RECORD

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Problem-Oriented Health Records

The **problem-oriented health record** is easier to use. This format is arranged according to a **problem list**. A problem list is an itemized description of the patient's past and present social, psychological, and medical problems. Each problem is indexed with a unique number, and reports and clinical documentation are keyed to the numbers representing the problems they address. The documentation is arranged in chronological or reverse chronological order. (See **FIGURE 6.1**.)

FIGURE 6.1

FIGURE 6.1. Example of a problem list

Anytown Community Hospital

INTERDISCIPLINARY PROBLEM LIST
AND PLAN OF CARE

PATIENT LABEL

Category:
Subcategory:

Problem List:
☐
☐

Discharge Outcomes

Target Date/ Initials	Key Interventions	Discipline	Start Date/ Initials	Stop Date/ Initials

Initials	Signature	Discipline	Initials	Signature	Discipline

Key
CM = Case Manager
DTC = Diabetes Treatment Center
ETN = Enterostomal Nurse
FSR = Financial Services Representative
HCC = Home Care Coordinator
NSG = Nursing
OT = Occupational Therapist
PC = Pastoral Care
PHM = Pharmacy
PT = Physical Therapist
RD = Registered Dietitian
RT = Respiratory Therapist
SLP = Speech/Language Pathologist
SW = Social Worker

Origin:

INTERDISCIPLINARY PROBLEM LIST

PROBLEM-ORIENTED HEALTH RECORD

In addition to the problem list, the problem-oriented health record contains the prescribed set of patient data, an initial care plan, and progress notes. Content of the problem-oriented health record includes the following:

- Chief complaint
- Present illness(es)
- Social history
- Medical history
- Physical examination
- Diagnostic test results

The initial care plan serves as an overall guide for addressing each of the patient's problems. The services described in the plan are numbered to correspond to the problems they address.

The patient's caregivers use progress notes to document how the patient's problems are being treated and how the patient is responding to treatment. Each progress note is labeled with the number of the problem it is intended to address. This problem-indexing system allows the clinician to easily follow the patient's course of treatment. Ideally, other elements of the health record (such as physicians' orders) are also numbered according to the problems they address. Information in the progress notes is organized using a sequence referred to as SOAP—an acronym that reminds the provider to address all four areas of patient care:

1. **S**ubjective information (such as patient complaint)
2. **O**bjective data (such as diagnostic test results)
3. **A**ssessment (diagnosis)
4. **P**lan (treatment)

Many physicians are trained in the use of SOAP notes during medical school and may use the SOAP format regardless of the health record format employed by the hospital. The biggest shortcoming of problem-oriented records is the inconsistent application of problem numbers to every piece of documentation.

INTEGRATED HEALTH RECORD (IMR)

- Lihat pada hlm.305

Integrated Health Records

The third format used for paper-based acute-care records is the **integrated health record**. The integrated health record is arranged so that the documentation from various sources is intermingled and follows a strict chronological or reverse chronological order. The advantage of the integrated format is that it is easy for caregivers to follow the course of the patient's diagnosis and treatment. The disadvantage is that it is difficult to compare related information or even to locate specific information

TUGAS INDIVIDU

1. Jelaskan perbedaan dari ketiga jenis format pendokumentasian rekam medis (RM) atau rekam kesehatan (RK)!
2. Sebutkan isi dari *Problem-Oriented Health Record* (daftar masalah) dalam format POHR!
3. Dalam format POHR juga dikenal pencatatan dengan singkatan atau akronim SOAP. Jelaskan masing-masing dan berikan contohnya!
4. Jelaskan keuntungan dan kerugian dari format RM atau RK terintegrasi (*Integrated Health Record)*!