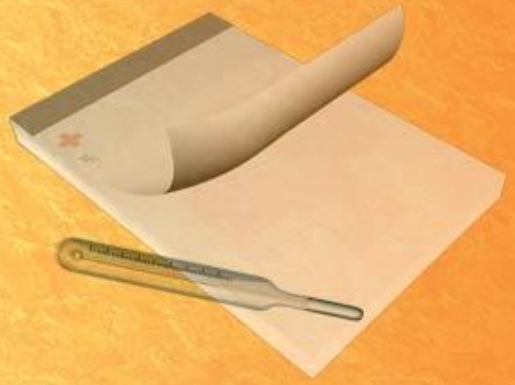
Today's Agenda: 8/22/14

1. Activity: Medical Terminology Bingo.
2. Highlight SC Standard in notebook:

   2.2 - Use appropriate medical terms to communicate information.

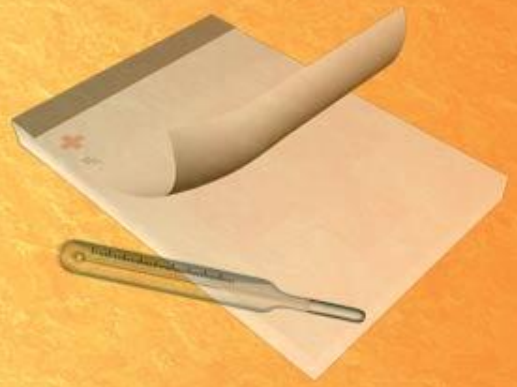
3. Today's Objective: How has medical documentation changed over the past fifty years?



Medical records management systems differ in the way pt (patient) files, or charts, are sorted, stored, retrieved, copied, and accounted for.

Records can be managed:

1. Manually
2. Electronically

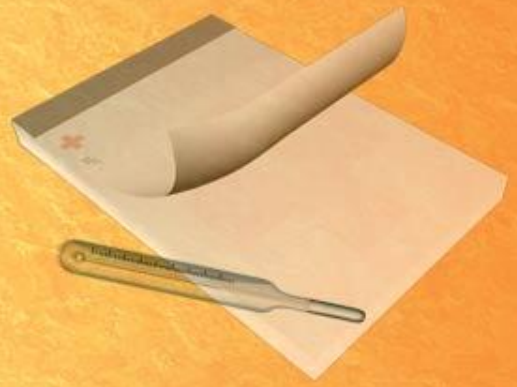


1. Manually:

In the hospital setting, manually maintained pt records are compiled by nurses and updated regularly until the pt is discharged.

The chart is then sent to medical records for storage.

Physicians regularly request old charts.
Insurance companies request for claims, audits, and legal evidence in court.



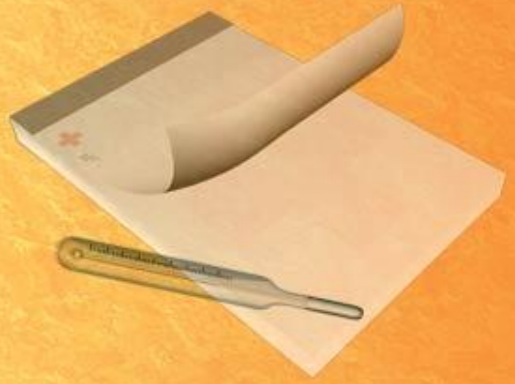
2. Electronic (EMR)

Records are kept on an Ipad and stored on a central server.

This is the newest way of keeping pt records.

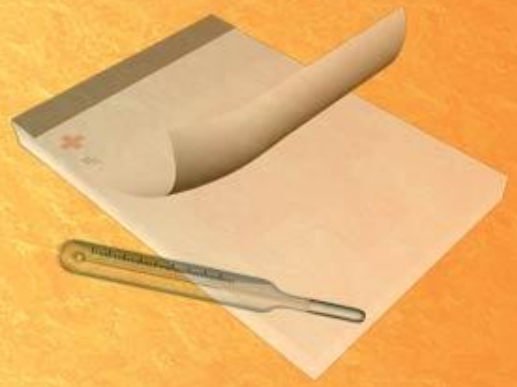
Much easier to manage records provided the system is working properly

Much easier to retrieve information from a variety of doctors, labs, and sources.



Medical records include information about the following:

* dates of examinations and tx (treatment)
* pt hx (history)
* detailed description of physician's findings
* results of x-rays and diagnostic tests
* statement of diagnosis
* detailed description of tx provided and results



Problem oriented medical record – 1960's

Lawrence Weed – medical student

- Needed a logical systematic way of charting pt records
- Divided into 4 main sections:
  - Database – pt history and current health status
  - Problem list – active problems that need attention
  - Plan – what is done to address problem
  - Progress notes – documentation of observations, assessments, care

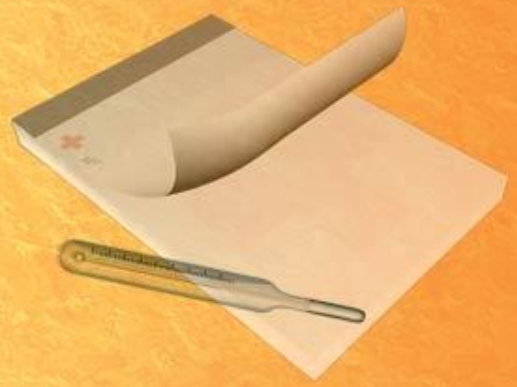
S O A P notes - develop by Weed to simplify previous plan

S – Subjective – details the pt tells you

O – Objective – observations, tests, exams

A – Assessment – diagnosis

P – Plan - rehab, treatment, surgery



Common Charting Terms

Acute - condition that happens quickly

examples: sprains, strains, cuts, wounds

Chronic – condition that develops over time

examples: tendinitis, emphysema

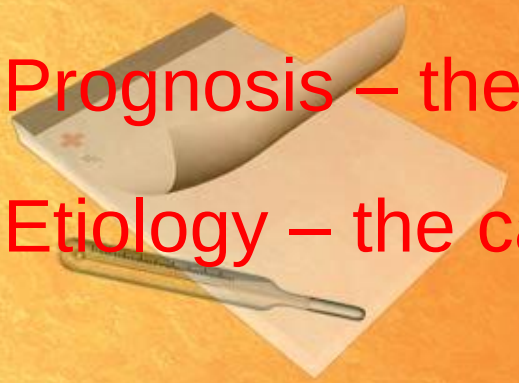
Benign – noncancerous

Malignant – cancerous

Diagnosis - the condition or disease

Prognosis – the prediction of the outcome

Etiology – the cause of the disease



Routes of Medication Administration

1. Inhalation – vapor or gas inhaled through the nose or mouth
2. Oral – taken by mouth
3. Parenteral – injection by syringe or intravenously
4. Rectal – suppository or liquid inserted into rectum
5. Sublingual - under the tongue
6. Transdermal – absorbed through the skin
7. Topical – lotions, ointments, and eye drops applied to a particular area.

Types of Injections

1. intradermal - into the skin

2. intramuscular - into the muscle

3. intravenous - into a vein

4. subcutaneous - beneath the skin into the fat