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Correspondence

UP-TO-DATE RECORDS OF LONG-STAY PATIENTS

DEAR SIR,

The difficulty of assessing long-stay patients, particularly for new members of the staff, or those dealing with emergencies, is a familiar one. The use of a cumulative type of records as suggested by Dr Henryk-Gutt (*Journal*, February 1980, **136**, 203–4) and the method suggested by Dr Roger Morgan (*Journal*, May 1980, **136**, 423–4) go a long way to remedy this problem. We would like, however, to report on the method we are currently using in a developing psychiatric rehabilitation unit, that of the problem oriented case records.

This is a modified version of Weed's original system (Weed, 1969) and those of Ryback (1974) and Mazur (1974). It is particularly adapted to meet the needs of a rehabilitation unit for new and old long-stay psychiatric patients (copies of the forms used and a booklet of guidelines are available by writing directly to the first author). The system is very flexible and can accommodate assessment forms, rehabilitation programmes, and the results of periodical reviews. It is not only a recording system but a practical approach to a group of patients handicapped by a number of problems which hardly fit any diagnostic category.

We use a special folder with two flaps in the middle. On one side of the folder we attach a full summary of all the previous notes, prepared and presented to the clinical team by one of the Medical Officers. This summary, together with any other important reports, form the 'data base' for this system.

On the other side of the folder we attach a number of forms:

(1) The problem list: formulated individually by members of the clinical team, and then pooled into one list which includes all the patient's problems both active (need attention or management) and inactive (resolved or dormant).

A quick glance at this list should provide an immediate summary of the patient's history, a comprehensive view of his current problems in the context of all the others. The list acts as an index for the whole system. Details of any problem can be obtained from the data base, and its course can be traced in the review forms, using the problem 'number' and the 'date it was first noticed' as tracers.

(2) Assets list: this is a deliberate effort to identify positive aspects in both the person and the environment, which are often overlooked in this group of patients.

(3) Initial plan: this is an operational plan based on the lists of problems and assets collectively drawn by the clinical team. Realistic aims are defined at this stage and specific items of the plan are assigned to specific members of the team. The plan aid its aims are regularly reviewed and modified accordingly.

(4) Review notes: this is a standard form used each time the patient comes up for review. It gives members of the team a chance to pool their observations periodically into one integrated document which gives a comprehensive view of the patient's progress. If new problems or assets were detected during the review, they should be added to the problem or assets list which must always be updated.

The system is operating in our unit, and we are embarking on a pilot project to evaluate the merits of its use and hope to report on this in due course. We would like to learn from those who have been using it, and would be very pleased to help those who would like to introduce it into their units.

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