SUBJECT: **ACTIVE AND INACTIVE PROBLEM LISTS**

A: GOALS:

1. To provide a complete, accurate and current health history that documents all present and past health issues affecting the individual's current function as well as health issues potentially requiring monitoring.

2. To implement a mechanism that assures that the Active and Inactive Problem Lists are current and accessible to all members of the interdisciplinary team as well as those consulting health providers whose assessments and interventions depend on the accuracy of this information.

3. To simplify the maintenance and accessibility of health information.

DEFINITIONS:

ACTIVE PROBLEM LIST: A list of all health issues that affect the individual's current functioning and all health issues potentially requiring monitoring. Active problems include chronic problems such as scoliosis, as well as acute problems. The Active Problem contains:

1. Allergies.
2. The etiology and level of the retardation.
3. Communication skills.
4. Ambulatory skills.
5. Seizures, if present, including type and frequency.
6. Behavioral problems, if present, including DSM diagnoses, nature of problem.
7. Cerebral palsy, if present, including type and location.
8. All health issues that affect the individual's current functioning.

INACTIVE PROBLEM LIST: The Inactive Problem List constitutes a history of the person's past, but resolved health problems. It contains, at a minimum:

1. All significant resolved past health issues that have the potential to recur or to cause other medical problems.

2. All past significant surgical procedures.

3. All significant diagnostic studies, with a brief notation of results.

4. All significant past medications, especially anticonvulsant and psychoactive, including the reasons for the discontinuation.

B. PROCEDURES:

A. The Active and Inactive Problem List are kept at the very front of the medical record in a plastic binder, with the Active Problem List as the front page and the Inactive Problem List placed behind it facing out. The record is reviewed and updated according to the schedule established in the Documentation Section of the Primary Nurse Role:

Health Care Level I-II: Annually, quarterly and at the time of any acute illness, diagnostic or surgical procedure, or medication changes.

Health Care Level III-IV: Annually, monthly and at the time of any acute illness, diagnostic or surgical procedure, or medication changes.

Health Care Level V-VI: Weekly or at the time of any acute illness, diagnostic or surgical procedure or medication change.

1. Active Problems are written in ink and in legible handwriting as medical diagnoses, and assigned a permanent number with a date of onset recorded, if known. Permanent numbers may be assigned by individual or by diagnoses, but the number should only be used one time for any given individual.

2. When the Primary Physician, in conjunction with the Interdisciplinary Team, decides that the problem has been resolved, it is transferred to the Inactive Problem List by the individual's Primary Nurse. The resolution date is entered on the Active Health Problem List, and a straight line is drawn through the #, Problem, Date of Onset and Resolution Date to give a visual cue that this is a resolved health problem. There should be a corresponding Inactive Problem recorded on the Inactive Problem List for each resolved Active Problem.

3. Diagnostic tests, the results and the date performed are entered under that section in the Inactive Problem List.

4. Medications, start dates, purpose of the drug, stop dates and reason for termination are all recorded under the Medication Section of the Inactive Problem List.

C. ASSESSMENT:

1. The Primary Nurse audits the Active and Inactive Problem List according to the schedule listed above to assure its continuous accuracy. When there are inconsistencies between the Active and Inactive Problem Lists, the Primary Nurse consults with the individual's primary physician for an opinion on the inconsistency, and corrects the error.

D. NURSING INTERVENTION:

1. The Primary Nurse adds new or missing Active Problems with the date of onset, if known, to the Active Problem List at the time of the audit. The entry is written in ink.

2. The Primary Nurse transfers resolved problems to the Inactive Problem List:
    a. By entering the resolution date and drawing a single line through the Problem #, Problem, Date and Onset and Resolution on the Active Problem List.
    b. By recording the resolved problem on the Inactive Problem List, along with its permanent number, the date of onset and the date of resolution.

3. The Primary Nurse records the occurrence and results of laboratory, radiology or other diagnostic tests, their results and the date the test(s) occurred within 7 days of the results. The primary nurse's initials on the diagnostic tests reports indicates that the information has been entered.

4. The primary nurse records changes in medications/dosages, the purpose of the medication on the Medication Section of the Inactive Problem List within 7 days, and initials the physician's order. Medications that have been either altered in dosage, or terminated will be entered.

E. COMMUNICATION:

1. **Nurse/Physician:** The primary nurse consults with the primary physician any time there is a discrepancy between the Active/Inactive Problem Lists and the medical record, and corrects the discrepancies according to the physician's instructions.

2. **Nurse/Resident Living Staff:** N/A

3. **Nurse/Nurse:** The Primary nurse instructs nursing staff to notify him/her at the time of any significant change in diagnoses, e.g. significant lab, x-ray or diagnostic test results or medications changes. The primary nurse initials the exam result to signify that that information has been entered under the Diagnostic Test section of the Inactive Problem List.

4. **Nurse/Interdisciplinary Team:** Primary Nurse verifies the accuracy of the Active/Inactive Problem List at the time of the annual review, or at interim or emergency team meetings.

F. HEALTH EDUCATION-NURSE/RESIDENTIAL LIVING STAFF: N/A

G. DOCUMENTATION: As specified in sections A through E above and according to the following specific instructions:

INSTRUCTIONS FOR COMPLETING FORMS

NAME: First name, last name and initial **D.O.B.** day/month/year **CASE NO.** Facility #

LEVEL OF RETARDATION: Mild, moderate, severe**,** or profound **D.O.A.** day/month/year of admission to ADC.

ETIOLOGY OF RETARDATION: Original cause of disability, if known.

ACTIVE HEALTH PROBLEM LIST (Current Medical Diagnoses)

Current Problem No. **PROBLEM:** Statement of medical diagnoses.

DATE OF ONSET: Date of diagnoses of the condition.

RESOLUTION: Date the condition was designated as "cured".

1. Seizure Disorder: Seizure diagnoses, if any, by current type and frequency. Otherwise mark N/A. Include date of diagnosis, if known, otherwise state "unknown". Date of resolution is not recorded until the problem is designated "inactive" and transferred to the inactive problem list. At that time, draw a single, straight line through the entire entry line, such that the entry is still legible, e.g.:

Example:

# PROBLEM	DATE OF ONSET	RESOLUTION
1. Seizure Disorder: Absence	9/8/65	10/12/72

2. Psychiatric/Behavioral: DSM diagnoses, if any and nature of problem. Otherwise N/A.

Example:

# PROBLEM	DATE OF ONSET	RESOLUTION
1. Seizure Disorder: Absence	9/8/65	10/12/72
2. Psychiatric/Behavioral: N/A	blank	blank

3. Cerebral Palsy: Cerebral palsy, if present, including type and location. Otherwise N/A.

Example:

# PROBLEM	DATE OF ONSET	RESOLUTION
1. Seizure Disorder: Absence	9/8/65	10/12/72
2. Psychiatric/Behavioral: N/A	blank	blank
3. Cerebral Palsy: Spastic Quadriplegia	1/9/65	lifelong disability, should not have a resolution date.

4. Allergies: Allergies, if any. Otherwise N/A.

Example:

# PROBLEM	DATE OF ONSET	RESOLUTION
1. Seizure Disorder: Absence	9/8/65	10/12/72
2. Psychiatric/Behavioral: N/A	blank	blank
3. Cerebral Palsy: Spastic Quadriplegia	1/9/65	
4. Allergies: Milk, cheese, and erythromycin	Unknown	blank

5. Other medical diagnoses with unique number.

Example:

# PROBLEM	DATE OF ONSET	RESOLUTION
1. Seizure Disorder: Absence	9/8/65	10/12/72
2. Psychiatric/Behavioral: N/A		
3. Cerebral Palsy: Spastic Quadriplegia	1/9/65	
4. Allergies: Milk, cheese, and erythromycin	Unknown	
5. Aspiration pneumonia, right lower lobe	7/5/89	7/21/89
6. Fractured right femur	3/20/93	4/10/93

7. Hiatal hernia with gastro-esophageal reflux	11/21/94	
8. Reflux esophagitis	1/21/94	2/24/95

INACTIVE PROBLEM LIST

(Resolved medical diagnoses, diagnostic test and medication history)

SIGNIFICANT ILLNESSES:

Includes old health history and resolved problems transferred from the Active Problem List.

Example:

SIGNIFICANT ILLNESSES

# PROBLEM	DATE OF ONSET	RESOLVED
Cholecystectomy	unknown	unknown
1. Seizure Disorder: Absence	9/8/65	10/12/72
5. Aspiration pneumonia, right lower lobe	7/5/89	7/21/89
6. Fractured right femur	3/20/93	4/10/93
8. Reflux esophagitis	11/21/94	2/24/95

DIAGNOSTIC TESTS:

Includes significant laboratory, radiology and diagnostic procedures, that is, where findings were significant, abnormal, or alter current diagnoses.

Example:

DIAGNOSTIC TESTS	RESULTS	DATE
CBC	Hct 32, Hg 9.	1/29/94
Barium Swallow	Aspiration of thin liquids, none with thick or puree	12/3/94
Upper GI Series	Large hiatal hernia, with 50% of stomach in chest	12/7/94

MEDICATIONS:

Reflects a continuous running record of past and current medications, reasons for prescribing, alteration in dosages and termination dates. Dosages may be expressed in total/24 hours or total with dose frequency. For example: Valproic acid 2400/24 or 600 qid.

Medication/dose	Purpose	Start date	Stop date/Reason
Tegretol 2400 mg/24	AED/Complex Partial SZ	10/25/89	12/13/89 CBZ toxicity
" 1800 mg/24	" " " "	12/13/89	

NAME_____ **D.O.B.** _____ **CASE NO.** _____
LEVEL OF RETARDATION: _____ **D.O.A.** _____
ETIOLOGY OF RETARDATION_____

ACTIVE HEALTH PROBLEM LIST

 # PROBLEM DATE OF ONSET RESOLUTION

1. **Seizure Disorder:** _____
2. **Psychiatric/Behavioral:** _____
3. **Cerebral Palsy:** _____
4. **Allergies:** _____

INACTIVE PROBLEM LIST

NAME: _____CASE NO: _____

SIGNIFICANT ILLNESSES_____

#____PROBLEM_____ONSET_____RESOLUTION_____

DIAGNOSTIC TESTS RESULTS DATE_____

Medication/dose Purpose Start date Stop date/Reason____