**Resident Guide- Note Writing**

**Inpatient Medicine Wards**

**Foundation**

-Note reflects the severity of illness for patient and **succinctly** delineates treatment plan

-Good notes displays a concise thought process, which is a way that you will be evaluated now and in the future

-Updates other providers and case managers

-Bills for the appropriate service

**General Principles**

-Accurate and up to date

-NOT COPIED from anyone

-Limit repetition (do not state PMH in HPI and in PMH section)

-Put things in the right place. Do not put data in the HPI or Assessment. Put it in the data section.

- Remember notes should be narrative

- Avoid inappropriate abbreviations (i.e.: 2/2 for secondary to or WWP- warm and well perfused)

- Remember to update health issues on an ongoing basis

- Do not argue in the chart- if you disagree with another service resolve this outside of the medical record

**History and Physical**

***Chief Complaint***- Reason for encounter

***HPI*-**

Focus on the chief complaint. (Remember, DO NOT state irrelevant past medical history in the HPI)

Remember to build a story to lead the listener to the diagnosis, strategically incorporating the seven elements of the chief complaint.

**Seven elements include: Location, chronology (onset and duration), severity, associated symptoms, quality, aggravating and alleviating qualities and impact/intervention**

Please don’t list events or facts that are loosely connected. Ask yourself, does the story make sense and does it answer the question within first 2 or 3 lines of “Why is the patient here today?” Remember, Quantity does NOT equal Quality!!!

ED course (optional): BRIEF summary statement of the pertinent events in the ED such as dramatic changes in clinical status(do not include specific antibiotics, CT scan results, or unnecessary labs)

***Review of Systems*:** At least 10 organ systems with pertinent positive and negative responses individually documented. You can refer to HPI and include the statement, “all other 10 point systems negative” however at least **4 must be specifically listed (i.e. no melena)**

***Past medical/surgical, family, and social history***

***Examination***

The medical record for a general multisystem examination should include findings about 8 or more of the 12 organ systems.

***Data****:* All Relevant Data! Try not to cut and paste but rather summarize displaying a thought process (path report, outside reports, etc.)

Labs, imaging, EKG, I&Os, pulse oximetry, glucometer, telemetry, outside records, path reports, endoscopy reports, peripheral smear

**Impression:**   Problem synthesis statement=One sentence synopsis of ACTIVE CLINICAL PROBLEMS in CONTEXT.

Active clinical problem:

Symptom, symptom complex, physical finding, test abnormality, clinical syndrome or health condition for which diagnostic evaluation or new management is being undertaken.

Context: The surrounding information that is pertinent (i.e. PMHx, social situation etc.)

Write it like this: This is the case of..[active clinical problem] in this person with …[context].

Example: This is the case of a 64 year old male presenting with shortness of breath and cough with a past medical history significant for COPD and alcohol abuse

*Or* 64 y/o man with a history of COPD and alcohol abuse presenting with shortness of breath, rhonchi in the right lung base and an abnormal Chest X-ray consistent with right lower lobe pneumonia

**Assessment:**      List of Active Clinical Problems

        List them in the order you will discuss them

        List co-morbid conditions that directly link to the active clinical problems

       By problem, create a structured discussion

**For each problem:**

                -Diagnosis or symptom with differential

                -Type or Stage

-Acuity (acute vs chronic) or severity (controlled vs. uncontrolled)

                -Etiology

-Lateralization

-Multisystem component/associated comorbidity

Example: Acute decompensated systolic heart failure due to dietary noncompliance with associated acute kidney injury.

**Plan:**

For each problem, state:

1.       Diagnostic plan

2.       Therapeutic plan

3.       Consultative plan- *make sure you state the reason for the consultation ( Cardiology consult for evaluation of acute myocardial infarction*

**Daily Progress Note**

**Subjective:**

**This should be an update of the seven elements of the chief complaint and any new complaints. Consider including** pain control, bowel/bladder complaints, nutritional status, mobility and other pertinent subjective elements.

Must **have at least two** elements. Focus on what the patient told you or family told you about the patient. **You can write “overnight events” in a separate subcategory to follow subjective.**

*For example*:

Subjective: Patient notes cough improving and sputum now white in color instead of green. Right sided chest pain resolved.

Overnight events: Patient desaturated to 88% and was placed on 4 L nasal cannula

**Objective:**

This is **focused** physical exam findings (5 areas required- e.g. vital signs/general, heart, lung, abdominal, extremity). The physical exam must be truthful and relevant. For example, do not write CN 2-12 intact, reflexes 2+ if you did not do the neuro exam that day and if it is not relevant to the active problem list.

Include only lab, radiology, and other study results that are new since the last note. Do not copy and paste a whole radiology read when you could simply summarize- “Chest x-ray revealed RUL pneumonia.”

**A/P:** **Updated active problem list.** You *SHOULD NOT* rehash all the rationale for making this diagnosis if it was previously documented. If the working diagnosis is uncertain, you still commit to the most likely diagnosis and then list any other diagnoses you are actively working up or empirically treating. Do not summarize data here. **Do not list chronic problems which you are not actively treating** (e.g. hypothyroidism on stable dose synthroid, dyslipidemia on statin, etc.)

You *SHOULD* for each problem state the diagnosis with the acuity, severity, type or stage, lateralization and if there is a multisystem component (any end organ damage involved)

**P- This is where you list the plan, tests, and/or therapies.** If it is not obvious why you are ordering something or initiating treatment you should provide rationale. (You would not repeat that comment in subsequent notes.)

**DO** for each Problem, state a diagnostic plan, a therapeutic plan, and add any consultants that are relevant for that diagnosis.

**Example:**

1. Acute Inferior Wall Myocardial infarction with Acute Systolic Heart Failure EF 30% and AKI

Diagnostic plan**:** Plan for Cardiac Cath on Monday, NPO after midnight

Therapeutic plan**:** Heparin gtt, Metoprolol, Lisinopril.Today we will give 40IV LASIX for goal of net negative 1.5L

Consultants**:** Cardiology for evaluation of acute MI; Nephrology for evaluation of rising serum Creatinine

1. Acute Decompensated systolic heart failure secondary to ischemic heart disease

Diagnostic plan**:** Echocardiogram today

Therapeutic plan: increase Lasix to 40mg IV daily, continue Coreg and Lisinopril

Consultants: Heart Failure team consulted for evaluation of CHF

DO NOT use the assessment and plan as a way to write the hospital course or record facts

DO NOT write a problem without having a plan.

DO NOT list several bullet points that are not associated with an actual diagnosis.

**ICU transfer notes: This should incorporated into a progress note**

**Admissions from outside hospital**:

Please remember that this should be an accurate summary of the highlighted events that has led the patient to be transferred. Only list specific antibiotics if relevant at the time of admission. Please do not include labs and unnecessary tests that were ordered and do not copy and paste data. Key parts to the summary include: Presenting symptom to the outside hospital, working diagnosis and how this diagnosis was confirmed, key diagnostic testing to confirm the diagnosis, reason for transfer and interventions to the point of transfer.

**Discharge Summary/Note**

**Goals**

1. To write an accurate and descriptive discharge diagnosis that describes a patient’s severity of illness.
2. Be brief but detailed in the hospital course
3. To communicate with outpatient physicians

*The discharge diagnoses need to be descriptive. This means that you should include the following if you can: onset (acute, chronic), anatomy/location (right vs. left, organ, artery/vein), complications, and etiology.*

**Principal discharge diagnosis:**

-main reason for hospital stay after hospital assessment; can be more than one

-Make sure when writing the problems mentioned in the H/P are carried all the way to the discharge summary. This should be a “reconciliation” of discharge diagnosis.

There are many times for example that an H/P will have sepsis written in the assessment/plan but not be mentioned in the discharge summary. Make sure we state that if sepsis was not found that we write that it was ruled out in the hospital course.

-If the patient has them, please include problems such hyponatremia and protein-calorie malnutrition (mild, moderate, or severe), and functional quadriplegia. These diseases reflect a higher mortality.

The goal is to write a diagnosis that **captures the severity of illness and justifies the patient’s duration of hospitalization**. For example, if a patient oxygen saturation was less than <90% or their PaO2 < 60 mm Hg from pneumonia, one should write Acute Hypoxic Respiratory Failure 2nd pneumonia. Writing just pneumonia doesn’t reflect the severity of the patient’s pulmonary disease. However, if the patient had normal saturation and was breathing comfortably, then it is appropriate to just write pneumonia. Now, if pneumonia is your diagnosis, it is very common that an organism is not isolated. Therefore, writing Bacterial Pneumonia 2nd presumed gram negative organisms” is more appropriate, particularly when the patient is at risk of such organisms and you are sending the patient on antibiotics that are covering such species. The billing world doesn’t recognize Hospital or Health Care Associated pneumonia. If the patient met sepsis criteria then you should write: “Severe Sepsis 2nd pneumonia from presumed gram negative organisms.”

**Chronic Problems**: List here the patient’s chronic medical problems that we watched over during the hospital. Write down if there were any changes to their medications. If there wasn’t any just write “no change to home medications were made” and “see medication list section.”

Examples include: uncontrolled diabetes with neuropathy and retinopathy, Hypertension with chronic renal disease, Chronic Systolic Heart Failure, Anemia of Chronic Disease related to malignancy.

**Hospital Course:**

When writing the hospital course, be succinct, but detailed. A play-by-play of all the events is not necessary when writing the hospital course. No one needs to know the daily WBC count or that you gave electrolytes during the hospital unless that was the primary issue. ICU hospital courses should be brief as well.

Example: Patient was admitted to the ICU for septic shock 2nd UTI that required vasopressors and intubation and was transferred to the medicine floor in stable condition.

Example: 55 year old man with pancreatic cancer presented with dyspnea x 3 days. He was found to be febrile, WBC 20, and CXR showed right lower lobe pneumonia. No organisms were isolated in the sputum or blood. His fever resolved and his WBC improved.

**Consultations:** (specialties)

**Procedures:** (Name of procedure)

**Images:** Mostly CTs, echocardiogram, MRI: DO NOT CUT AND PASTE. Give your summary of the results.

**Complications:** (the development of UTI, pneumonia, sacral decubitus ulcers, line infections, DVT, adverse drug reactions)

**Outpatient Plan:**

Issues to be addressed at follow-up.

State if prescriptions were printed out or sent electronically to their pharmacy. Write down the name of the physician if known and what clinic the patient is going to follow up with. Also state here if home health or home safety evaluation was filled out. Give the patient **specific** instructions. (Don’t write f/u with PCP in 1 week; give reasons why the patient has to f/u; this serves as motivation for the patient to see his or her doctor).

**Consult Notes**

Guiding Principles- *similar to H&P above, with the following exceptions:*

1. The consult note should clearly state the reason for the consult (primary team’s questions to consultant)
2. It is required that the referring physician be documented in the note
3. Don’t regurgitate the primary team’s H&P from admission in your consult note. Instead, focus on the question you were asked and the information that is pertinent to this question. There is no need to include the entire hospital course.

**Example:** 54 year old male admitted with appendicitis s/p laparoscopic appendectomy referred for evaluation of uncontrolled hypertension.

Additional history may be relevant depending on the service you are representing. For example, the ID service may be more interested in social history (drug use, homelessness) and past medical such as prior infections or antibiotics treatment history.

1. Past data included in the note should be focused and relevant as it relates to the consult question (i.e. a consult for management of DM should include the trend of glucose levels/fingersticks)
2. There should be no fighting in your consult note. Disagreements should be resolved outside of the medical record.

**Assessment:**

The assessment should be a list of problems relevant to the consult with **the reason for referral listed FIRST**. Other active issues within the scope of the consulting specialty should also be included. If it is needed, this is where you can defend your diagnosis, explain your thought process or address the primary teams differential diagnosis.

Your assessment should be straightforward, and written in a manner that you would want your consultant to write it to you. It should address the primary teams concerns.

Do not reiterate symptoms, HPI, etc. You can simply state, “By history and physical exam, the most likely diagnosis is vasovagal syncope”.

Commit to the most likely diagnosis. If you don’t know, you can mention those less likely or state “unclear etiology.”

**Plan:**

-This should be a list of your diagnostic and therapeutic plan. Include a succinct rationale for your recommendations.

-Be specific- as an “order” you would place in QUEST. (i.e.: name of medication, dosage, frequency, duration, when to initiate)

-Provide appropriate precautions and contingent recommendations (ex. Order a troponin level at 6pm- if it is elevated >.5, consult cardiology).

-Be specific with the urgency of your recommendations. Indicate when the diagnostic or therapeutic order needs to be placed (i.e. immediately, tonight, in the morning, or after discharge)

-Appropriate terminology for your plan includes:

1. A command: “Increase” basal insulin to 30units sc tonight
2. A recommendation: “Recommend” starting lisinopril 20mg po qday for proteinuria
3. “Suggest”
4. “Consider”
5. “Agree” with management the primary team has initiated regarding the consulting question
6. “Defer to” for other specialists consulting on management also within your scope of practice

-If you sign off, please leave a contingency plan in your last note

-At the end of your note, include who you discussed the case with (attending and fellow) and who to call with questions (and appropriate contact information- pager, phone extension, etc.)