

New Student Progress Note Format

Justification:

With the implementation of EMR, attempts to conform the time-honored SOAP note to EMR have resulted in a chimera of dubious format and value. The reasons for this failure are myriad but mostly stem from the author losing sight of the purpose of the note which is:

- 1) To communicate to other members of the health care team your thoughts about the patient concerning:
What has transpired in the hospital.
Your assessment about the wellbeing, diagnosis and plan for the patient.
- 2) To justify billing to third party payers through the intern note.
- 3) To communicate a learner's knowledge and clinical skill to the members of the health care team who will be submitting their evaluations.

Some would also add:

- 4) To defend your actions concerning the care of the patient in a court of law.

Knowing why you are writing the note makes it much easier to construct a good note.

An additional new problem has to do with copying and pasting. While doing so is an efficient means of fulfilling the documentation requirements for billing at higher levels, the rampant misuse of copying and pasting has only interfered with patient communication rather than assisting it. The situation has become so serious that some insurance companies have demanded that they be reimbursed for billing based on notes that include any copy and paste information. Some hospitals have even gone so far as to disable the copy and paste option in the EMR.

Since no billing can be based on student notes, there is no justification for copying and pasting (except to document a lengthy report from a radiological procedure).

New Format:

Interim History: Write what has happened to the patient since yesterday's note. Includes subjective data, as well as information from cross cover and hand-offs, and any nursing report.

Officially, "Subjective" should only include information from the patient or patient care-giver. Nursing and physician notes are considered expert information and therefore, objective in nature. However, residents have over time, transformed the "S" to an interim note, including all information to describe everything that occurred in regards to the patient since the last note. As such, this section should really be a quick overview rather than a lengthy discussion.

Objective: Vital signs, physical exam, lab and procedure results – not interpretation.

In this section the student should document pertinent positive and negative findings on exam. Lab and procedure results with radiologists' interpretation should go here, (however, learner interpretation should be documented in the discussion of the relevant problem below.)

Again, the hospital can bill from the data in the intern note but not the student note. Interns must include a certain number of systems to be able to bill at certain levels even if the information is not relevant to the care of the patient. Students, on the other hand, should not include any information that does not directly contribute to the care of the patient. Typically, students will include a litany of findings that communicate nothing about the patient and only interfere with good communication, presumably to make the note seem more robust. Example: NCAT on a patient who has been in the hospital for days. Writing this abbreviation implies to the reader that the student thought that overnight the patient would become micro- or macrocephalic or that someone would beat them about the head while in the hospital. Don't just put in "filler" to make the note seem longer. It interferes with communication and makes the reader more likely to "skim" or skip the note altogether.

Assessment: *This section has deteriorated to a rewriting of the HPI, even if the patient has been in the hospital for weeks and the diagnosis known and treated. Individual problem assessment will now occur in the problem list and overall assessment in the Disposition.*

Problem List:

List each problem, not system. *(System listing is best used in the ICU since most systems are involved. Rather, using a system approach is a tool to help remind the student of all the patient's problems. Do not list systems that have no problems.)*

The first problem addressed should be the primary problem for which the patient was admitted.

Interpretation of pertinent physical findings, **current** lab and radiology reports, procedure results. *(Do not rewrite results already documented in the Objective section. Do not include results already documented in a previous note.)*

Calculate antibiotic date, hospital days, I&O's, cc/kg/day, kcal/kg/day, cc/kg/hr., change in weight, where appropriate.

Give an assessment of this problem- better, worse, resolving, etc. *(If it's a new problem, the student may need to give a differential diagnosis list, sort appropriately and defend.)*

Write a plan to address this particular problem, contingencies, etc.

Treat each problem in the same way.

Despite the fact that the "P" in SOAP stands for Plan, this portion of the note has transitioned over time into a problem list. Unfortunately, the interns have been copying and pasting the same information each day for each problem, simply adding newer information to the end of the paste or highlighting it as different. It has come to include a wealth of data rather than just a plan, however, this action is understandable since this is logically how we address problems- in toto rather than divided up into 4 separate sections. The superfluous repetition of ancient information leads to confusion and discourages attendings from actually taking time to read the entire note.

Disposition: May give overall assessment here –the patient is overall better, worse, improving, etc.

Do not rewrite HPI!!!

This will be the location of the overall assessment, the individual assessment of each problem having already occurred in the problem list.

Try to guestimate potential discharge date.

Anticipate home needs – home health, durable medical goods, etc.

Case management is requiring this portion in the note already so rather than have a separate assessment and disposition, it makes sense to combine them.

- NO copy and pasting.
- Avoid redundancy!
- Writing the note in this format will lend itself very effectively to presentation on rounds.

Sample: Problem Oriented Note:

4/28/2014

Medical Student Note

6:45am

Hospital Day #2

Interim: Mother stated that the Princess passed several diarrheal stools last night requiring frequent cleaning all night with wipes and that she hardly drank anything. She felt as though she had fever although one was never documented and she had no further vomiting. She said Princess didn't sleep well which may have been due to lots of interruptions- IV beeping, nursing coming in and out of the room, etc. Mom states that Princess now has a diaper rash. We verified in hand-off that her IV infiltrated and was removed this morning.

Objective:

PE: Wt: 7.1kg (admit weight: 6.8kg)

VS: Tmax: 37.5C BP: 74-90/56-78 RR: 20-40 HR: 90-150

Awake, alert, active, good skin turgor

HEENT: Soft AF, MMM, no conjunctivitis, TM's clear, good light reflex

Chest : CTA, no increased work of breathing

Heart: unable to hear a murmur this morning, normally split S2

Abd: supple, non-tender, no masses, no HSM, no guarding, no rebound, small umbilical hernia-easily reducible

GU: Tanner 1 female, erythematous macular rash with some desquamation in diaper area

Ext: FROM, no cyanosis

Am BMP: Na: 135 K: 4.0 Cl: 100 HCO: 3:21 BUN: 8 Cr: .4 Glu: 90 Ca: 9.0

I&O's 145 cc/kg/day but only 26cc/kg/day oral intake

Urine output: 2cc/kg/hr

Balance: +190

Problem List:

- 1) 7 mos/o with viral Gastroenteritis and dehydration now well hydrated on IV fluid. She was estimated to have been 5-7% dehydrated and gained 4% of her well weight overnight, gaining 300gm despite continued diarrhea. Her urine output was excellent at 2cc/kg/hr. Since Princess is now well hydrated and no longer vomiting, will leave IV out to see if she will be able to maintain hydration by herself. Begin contact isolation.
- 2) Mild metabolic acidosis probably secondary to dehydration with slightly elevated BUN- now resolved with hydration alone. No need to F/U unless diarrhea persists.
- 3) Poor oral intake through the night, only 26cc/kg/day, is probably secondary to IV fluids. We anticipate her appetite improving now that fluids are discontinued. If it doesn't pick up by this afternoon and diarrhea persists, will have to restart IV to maintain hydration.
- 4) Transient heart murmur last night now resolved with hydration- possibly a flow murmur due to dehydration or viremia. Will discuss with PCP to follow after discharge.
- 5) Fever - mom thought there was fever but one was never documented. Will continue to monitor.
- 6) Umbilical hernia - no evidence of incarceration and is therefore not a cause of her acute GI issue. If it doesn't resolve before 4 y/o her PCP will refer her to pediatric surgery for repair.
- 7) Diaper dermatitis secondary to diarrhea and excessive cleaning. Will recommend gentle cleaning with soap and warm water rather than scrubbing with harsh wipes. Allow to air dry and then apply zinc oxide barrier cream.

Disposition:

7 month old WF admitted with AGE and dehydration improved with IV hydration. If able to tolerate oral intake and maintain hydration, may d/c to home today or tomorrow morning.

Example: Traditional SOAP Note

4/28/2014

Medical Student Note

6:45am

Hospital Day #2

Subjective: Mother stated that the Princess passed several diarrheal stools last night requiring frequent cleaning all night with wipes and that she hardly drank anything. She felt as though she had fever but she denied any further vomiting. She said Princess didn't sleep well which may have been due to lots of interruptions - IV beeping, nursing coming in and out of the room, etc. Mom states that Princess now has a diaper rash. She said the IV just fell out this morning.

Objective:

PE: Wt: 7.1kg (admit weight: 6.8kg)

VS: Tmax: 37.5C BP: 74-90/56-78 RR: 20-40 HR: 90-150

Awake, alert, active, good skin turgor

HEENT: Soft AF, MMM, no conjunctivitis, TM's clear, good light reflex

Chest: CTA, no increased work of breathing

Heart: unable to hear a murmur this morning, normally split S2

Abd: +BS, supple, non-tender, no masses, no HSM, no guarding, no rebound, small umbilical hernia-easily reducible

GU: Tanner 1 female, erythematous macular rash with some desquamation in diaper area

Ext: FROM, no cyanosis, good cap refill

Am BMP: Na: 135 K: 4.0 Cl: 100 HCO: 3:21 BUN: 8 Cr: 0.4 Glu: 90 Ca: 9.0

I&O's 145 cc/kg/day but only 26cc/kg/day oral intake

Urine output: 2cc/kg/hr

Balance: +190

Assessment:

- 1) 7 mos/o with viral Gastroenteritis and 5-7 % dehydration now well hydrated on IV fluid. Findings consistent with viral illness. No need for further work up unless symptoms change or persist.
- 2) Mild metabolic acidosis probably secondary to dehydration with slightly elevated BUN- now resolved with hydration alone
- 3) Poor oral intake - possibly secondary to IV fluids
- 4) IV infiltrate - not necessary to restart at this time.
- 5) Heart murmur last night now resolved with hydration - possibly a flow murmur due to dehydration or viremia.
- 6) Fever- mom thought there was fever but one was never documented
- 7) Umbilical hernia - no evidence of incarceration
- 8) Diaper dermatitis secondary to diarrhea and excessive cleaning

Plan:

- 1) Since baby is now well hydrated and no longer vomiting, will leave IV out to see if she will be able to maintain hydration herself. If able to tolerate oral intake and maintain hydration, may d/c to home today or tomorrow morning. Contact isolation.
- 2) Mild metabolic acidosis- resolved with hydration. No need to F/U unless diarrhea persists.
- 3) Poor intake believed to be secondary to IV fluids. Now that IV is out, will see if her appetite improves. If it doesn't pick up by this afternoon and diarrhea persists, will have to restart IV to maintain hydration.
- 4) Do not reestablish IV unless negative fluid balance occurs.
- 5) Transient heart murmur- Discuss with PCP to follow after discharge.
- 6) No documented fever so no need for further evaluation
- 7) Umbilical hernia- monitor until 4 y/o, then refer to surgery.
- 8) Gentle cleaning with soap and warm water rather than scrubbing with harsh wipes. Allow to air dry and then apply zinc oxide barrier cream.