# Appendix 1

# Best Practices for Writing Inpatient Progress Notes

QUIPDOC (Quality of Inpatient Provider Documentation) Task Force
June, 2011

## QUIPDOC Task Force Goals

1. Improve the "readability" of inpatient notes in the EHR
2. Enhance patient care by highlighting important clinical information and diminishing note "clutter"
3. Improve quality metrics reporting
4. Meet the needs of hospital coding and professional billing
5. Improve communication and education regarding best practices between faculty and house staff.

## Background

Many believe that the quality of provider documentation has declined with implementation of the electronic health record. The QUIPDOC Task Force was commissioned to address this concern and to assist providers in defining the best practices for writing inpatient clinical notes in the EHR.

An additional observation by group members is that a dichotomy has developed within ours and other teaching institutions. The more senior clinical faculty have the greatest clinical experience and hold an "institutional memory" of best practices for inpatient notes. But it is often the most junior clinicians who are most facile with the EHR and quickest to experiment with and develop new methods for note creation in the EHR. These methods are then passed laterally among colleagues and may or may not match preferred practices by faculty who are co-signing the notes.

QUIPDOC Task Force members include hospital and professional coding staff, health information management staff, information services analysts, residents and faculty members. The Task Force has worked over the last several months to first define the best practices for writing inpatient *progress notes* in the EHR. Other note types will be addressed in the future.

## Defining the Ideal Progress Note

While serving as a concise interpretation of qualitative and quantitative data, a modern reality is that the progress note is also a key element of hospital coding, professional billing, and quality metrics reporting. To that end, many clinicians have erred on the side of "over-inclusion" to insure capture of all regulatory items

and meet hospital billing and coding requirements. This has added to what has been coined “note bloat”.

The electronic health record presents a new paradigm in the review of patient data. Within the paper chart, the progress note served as the data review tool, but within the EHR, data are more readily available for review and do not necessarily need to be included in the note.

The ideal EHR progress note serves as the synthesis of these data and conveys the thinking and medical decision making of the clinician. The Best Practice Recommendations outlined in the following table are written to assist providers in meeting this ideal.

The table also includes the minimum requirements for professional billing and hospital coding in order to address a frequently raised question about “what exactly needs to be included in my note?”

## Implementation of Best Practice Recommendations

1. Many services use templates or macros when writing daily progress notes. The Task Force has developed a standard template that reflects the best practice recommendations. Attendings and residents who utilize templates in writing progress notes are encouraged to use this backbone template and adapt it to meet their individual service needs. Individuals may also choose to revise existing smart phrases to reflect the best practices.
2. The Best Practices should be used as the guiding principles in the development of any progress note templates.
3. Attendings are encouraged to familiarize themselves with the best practices and use them as a basis for providing feedback to residents and medical students on the quality and content of their daily progress notes.
4. After initial implementation of these best practices, these recommendations will form the basis of a note evaluation tool. Such a tool would allow administrative assessment of progress notes, and help frame feedback to clinicians regarding compliance with these best practices.
5. It is expected that these best practices will form a “living document” that should trigger communication and regular review. With ongoing institutional learning and new EHR features, periodic comparison between the core best practices and current note templates in actual use will allow ongoing improvement.

| Note Elements | QUIPDOC Best Practice Recommendations | Minimum requirement for professional billing/ hospital coding |
|---|---|---|
| Note Type | The note type is selected by the author when creating a new note. The author should confirm the correct note type when initiating a note. | Required to define service rendered |
| Author Title | The author's title should identify the service and the training level of author (Family Practice PGY2, Cardiology Fellow, General Medicine Attending, etc.). Auto-generation of these elements is often inaccurate. | Service and level of author defines who receives credit for the note. |
| Header | The header should include the patient's name, DOB, and MR number. | Not required |
| Admit Date/ Hospital Day | Inclusion of this information is optional. Recommend care if using hospital and post op day.. | Not required |
| Interval History/ Subjective | Describe events over the last 24 hours, relevant changes in the patient's condition, and the patient's report of how he/she is doing. This narrative should not be copied forward from the previous day's note and should not be an entire history of the patient's stay. | Required |
| Medications | The current medication list does NOT need to be included in a daily progress note. Pertinent changes should be noted here or as a part of the assessment and plan.<br>Pulling in a full list of current medications is unlikely to improve the value of the note and may become outdated quickly depending on the timing of when a note is written. If an author finds it necessary to pull in a medication list, we recommend placing this list at the bottom of the note to minimize clutter. | Not required |
| Vital Signs | Recommend stating "Vital signs from the last 24 hours have been reviewed and are pertinent for…" If vital signs are included, reduce clutter by pulling in only 24 hour mins/maxs and the last set of vitals. Pulling in multiple sets of vital signs is discouraged. | Not required but may satisfy the constitutional system within the physical exam used in determining level of service. |
| Is/Os | Recommend commenting on specific input and/or output measures (such as from drains) that are important in clinical decision-making. | Not required |
| Physical Exam | Document exam findings that are relevant for the patient and performed on that day. Delete from a template any system that was not examined that day. Do not copy forward exam from previous day. | Documentation is required for billing and coding. Refer to UWMF resources regarding PE and relationship to level of service. |
| Lines/Drains /Airway | If included, do not copy forward from previous notes. Include date of line placement not "line day" | Not required |

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| Labs and Cultures | Recommend a workflow of reviewing all labs and then stating "All labs have been reviewed. Pertinent labs include…" Labs pertinent to the assessment and plan of specific problems can be included in those sections. | Not required but lab interpretation is part of medical decision making in determining level of service. |
| Imaging studies | As appropriate, recommend stating "Recent imaging studies have been reviewed and are notable for…" Do not pull in report verbatim with copy/paste. Provide interpretation of the results. | Not required but interpretation of imaging results is part of medical decision making in determining level of service. |
| Problem List | If the problem list is being used in daily documentation, problems should be refined throughout the patient's hospital stay to accurately reflect the patient's current clinical condition. Problems should be reconciled daily. Assessments and plans may be written by problem on a daily basis | Not required |
| Assessment | Assessment should be the interpretation of the collected data with precise language of problems and/or diagnoses (e.g. creatinine of 8.0 should not be restated but instead interpreted as acute renal failure; Hct 23 should not be restated but interpreted as acute blood loss anemia) | Must include an assessment for each problem being addressed on that day |
| Plan | The plan should include the actions to be carried out to address specific problems for the patient on that day. | Must include a plan for each problem being addressed on that day |
| Signee Name | | Required |
| Signee Level | May be redundant with "Author Title" above for short notes. Recommend including at the bottom for longer notes that will need scrolling to read. | Not required |
| Signee contact info | Recommend including at least pager, cell phone or office number. | Not required |
| Attestation | "I have seen and examined the patient and agree with the resident's findings, assessment and plan with the following exceptions/additions…My impression is…" | Requirements vary depending on service and level of original author (e.g. med student, resident, fellow) |