WRITING CLINICAL NOTES

Intro to Clinical Practice

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Agenda

- Introduction to writing clinical notes
- Basic structure of common types of clinical notes:
  - *Admission Note*
  - *ED Note*
  - *Progress Note*
  - *OR Note*
  - *Delivery Note*
  - *Procedure Note*

Introduction: Why do we write notes?

- Document what happened so we can refer to this later
- Communicate with our colleagues
- Medicolegal concerns

As a learner, it also poses an opportunity to demonstrate your understanding of the patient's issues to your team!

Important Elements for All Notes

Date & Time

Clarity

- Heading and sub-headings
- Legible writing for paper charts
- Document the service you are working for and your designation
  - E.g. MTU MS2

Accuracy

Admission Note

- Important for most of your inpatient rotations:
  - *MTU*
  - *Surgery*
  - *Pediatrics*
  - *Etc*
- Written when admitting a patient to your team's service.
- Depending on the clinical service and location, these may be hand-written in a hardcopy chart/binder, dictated, or typed into an electronic medical record
- Slight variations in content and style depending on clinical service, but share a common basic structure

Admission Note – History

- **Heading** – include clinical service, note type, and your designation
  - Pediatrics Admission Note (MS2)
- **ID (Identifying information)** – Age, sex, any significant medical condition or contextual factor that will impact their care, and their chief complaint
  - 7 year old previously healthy boy with known asthma presents with 5 day history of cough and shortness of breath
- **GOC (Goals of Care)**
- **HPI (History of Presenting Illness)** – summary of what happened including pertinent positives and negatives
- **PMHx (Past Medical History)** – numbered list of issues with relevant details
  - 1. Asthma, on salbutamol prn only, no previous hospitalizations

Admission Note – History cont.

- **Medications** – doses, clarify what they are actually taking. Include OTC meds, herbals, etc.
- **Allergies** – list including reaction type
  - E.g. Penicillin – rash
- **Famhx (Family History)** – medical conditions in the family
- **SocHx (Social History)** – relevant details will vary based on service type and patient population, but may include:
  - social context (occupation, living situation, SES, social supports, religious beliefs, etc.)
  - level of functioning (mobility, ADLs, IADLs)
  - substances (smoking, alcohol, drug use)
  - immunization history

Admission Note – Objective Findings

- **O/E ("On exam" i.e. Physical Exam)**
  - Vital signs – HR, RR, BP, SpO2, Temp
  - General – your impression when you first walk into the room
  - HEENT
  - CVS
  - Resp
  - Neuro
  - Derm
  - MSK
- **Investigations**
  - Labs
  - Imaging

Admission Note – Impression & Plan

- **Assessment** – What do you think is going on? Should include a differential diagnosis if relevant.
- **Plan** – What are you going to do? It is often useful to present your assessment and plan (A/P) in a problem list, with medications, investigations, interventions for each issue:
    1. Congestive heart failure:
        - *Continue Lasix 40 mg IV BID*
        - *Arrange transthoracic echocardiography…*
    2. Acute kidney injury:
        - *Hold ACEi and recheck Creatinine tomorrow AM*

  Disposition should be included in your A/P list!
    - Where do you expect they will be going after hospital (Home? Long-term care? Hospice?)
    - When do you anticipate this happening?
    - What are the barriers to discharge?

ED & Urgent Care Notes

- Basic structure & sub-headings are similar to Admission Notes, but tend to be more brief
- You should add to your note as information (e.g. imaging results) becomes available, and document the time.
- Management often occurs simultaneously to the assessment
  - e.g., stabilizing the patient, providing analgesia, reassessing the patient
  - Any interventions should be documented in the ED record
- Add “Discharge Instructions" for patients you are sending home
  - e.g. management plan, what to expect, any follow-up required, reasons to return to ED

ED & Urgent Care Notes

- **Identify yourself:** document time you saw the patient, sign & write your name and your designation
- **ID (Identifying information)**
- **GOC (Goals of Care)**
- **HPI (History of Presenting Illness)**
- **PMHx (Past Medical History)**
- **Medications**
- **Allergies**
- **Famhx (Family History)**
- **SocHx (Social History)**
- **O/E (Physical Exam):** you may need to repeat vitals!

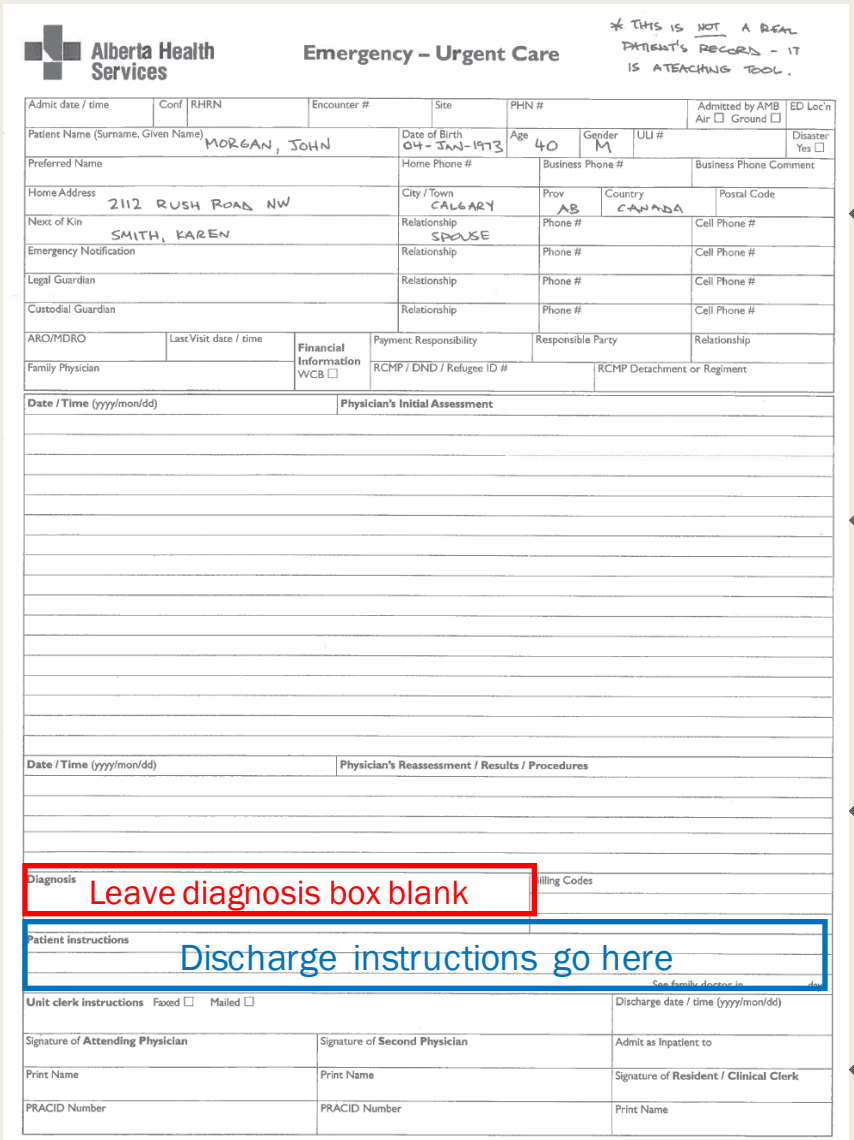
Investigations: labs & imaging

- Useful to add these to the note as results become available.

[**Assessment & Plan:** This section tends to be ***verbalized*** rather than documented in Emerg notes. Be prepared to present to your preceptor what you think is going on, your DDx, and your plan.]

Discharge instructions: document and discuss verbally with the patient

ED & Urgent Care Notes



Alberta Health Services

Emergency – Urgent Care

* THIS IS NOT A REAL PATIENT'S RECORD - IT IS A TEACHING TOOL.

Admit date / time	Conf	RHRN	Encounter #	Site	PHN #		Admitted by AMB Air ☐ Ground ☐	ED Loc'n
Patient Name (Surname, Given Name) MORGAN, JOHN				Date of Birth 04-JAN-1973	Age 40	Gender M	ULI #	Disaster Yes ☐
Preferred Name				Home Phone #		Business Phone #		Business Phone Comment
Home Address 2112 RUSH ROAD NW				City / Town CALGARY		Prov AB	Country CANADA	Postal Code
Next of Kin SMITH, KAREN				Relationship SPOUSE		Phone #		Cell Phone #
Emergency Notification				Relationship		Phone #		Cell Phone #
Legal Guardian				Relationship		Phone #		Cell Phone #
Custodial Guardian				Relationship		Phone #		Cell Phone #
ARO/MDRO	Last Visit date / time	Financial Information WCB ☐		Payment Responsibility		Responsible Party		Relationship
Family Physician				RCMP / DND / Refugee ID #		RCMP Detachment or Regiment		

Date / Time (yyyy/mon/dd)	Physician's Initial Assessment

Date / Time (yyyy/mon/dd)	Physician's Reassessment / Results / Procedures

Diagnosis — Leave diagnosis box blank

Billing Codes

Patient instructions — Discharge instructions go here

See family doctor in ___ day

Unit clerk instructions Faxed ☐ Mailed ☐		Discharge date / time (yyyy/mon/dd)
Signature of **Attending Physician**	Signature of **Second Physician**	Admit as Inpatient to
Print Name	Print Name	Signature of **Resident / Clinical Clerk**
PRACID Number	PRACID Number	Print Name

Demographic Info

Physician's Initial Assessment = YOUR NOTE!

Physician's Reassessment / Results / Procedures

Sign here

ACTIVITY: ASTHMA EXACERBATION

1. Split into 4 groups.
2. First, write your note individually on the ER chart template.
3. Next, share your note with your group.
4. Discuss how to improve the notes, and do a “final group copy” on the whiteboard.
5. Share with the workshop class.

Any questions about the following types of clinical notes?

– *Admission Notes*

– *ED / Urgent Care Notes*

Part 2: Specific Types of Clinical Notes

- Progress Notes
- OR Notes
- Delivery Notes
- Procedure Notes

Progress Notes (SOAP)

Used when rounding on admitted inpatients, and follow-up visits for outpatient rotations.

- **ID (Identifying information):** same format as admission notes
- **S (Subjective):** what the patient and family tells you, using their own words when possible. Focus on what's changed since the last progress note. May also include information from nurses, OT/PT, dietician, etc.
- **O (Objective):** include your physical exam findings and any new labs or investigations
- **A / P (Assessment & Plan):** often presented as a numbered list. Should include disposition.

OR Notes

These will be used on surgical rotations to document an operative procedure.

Pre-op Diagnosis:

Post-op Diagnosis:

Procedure:

Surgeon (Attending):

Assistants: Staff/Residents/Clerks

Anesthesia: Anesthesiologist / Type (e.g. GA, spinal, etc)

- *Ask the anesthesiologist if you don't know!*

Findings:

EBL (estimated blood loss): look in the suction containers, ask the team

Specimen: i.e. if sent for pathology

Drains: If placed, list here

Complications:

Disposition: Recovery room, Surgical ICU, etc

Plan: i.e. post-op management

OR Note – Example

- **Pre-Op Diagnosis:** cholecystitis
- **Post-Op Diagnosis:** same
- **Procedure:** Laparoscopic cholecystectomy
- **Surgeon:** Dr. Lin
- **Assistants:** James (R1), Yee (CC3)
- **Anesthesia:** Dr. Jones / GETA (General Endotracheal Anesthesia)
- **Findings:** Intraabdominal adhesions, distended GB, gallstones
- **EBL (estimated blood loss):** minimal
- **Specimen:** GB to pathology
- **Drains:** None
- **Complications:** None
- **Disposition:** To Recovery Room, extubated, in stable condition
- **Plan:** Transition from clear fluid diet to DAT, stop antibiotics, saline lock IV when drinking well, Tylenol #3s for pain relief, Discharge home in AM

Delivery Notes

These will be used on the Labour & Delivery unit after the birth of a baby.

- **Attending / Assistants** (Residents, Medical Students)
- **Type of delivery** (e.g. SVD, forceps, vacuum) of **live male/female infant**, **APGARS** (e.g. at 1 and 5 mins), **birth weight**, **complications** (e.g. nuchal cord, meconium, neonatal resuscitation)
- **Delivery of placenta** (e.g. placenta delivered spontaneously, gentle cord traction, etc.), **describe placenta and cord** (intact, 3 vessel cord)
- **Describe tears** and suture material used if repaired
- **EBL** ask your staff if you don't know
- **Medications** given at the time of delivery (oxytocin is most common)
- **Any other complications or pertinent information** (e.g. postpartum hemorrhage)

Delivery Note - Example

Dr. Black/O'Brien MS2

SVD of live male infant, APGARs 7-9, 3245 grams, nuchal cord x1

Placenta delivered spontaneously and intact membranes, 3 vessel cord

2nd degree perineal tear repaired with 3-0 vicryl. Small peri-urethral tears bilaterally (not repaired)

EBL 250 cc

Medications: oxytocin 10 U IM given with delivery of anterior shoulder

No postpartum complications

Procedure Notes

These should be written whenever a procedure has been completed

- **Procedure:**
- **Performed by:**
- **Attending Physician:**
- **Indications:**
- **Patient consent:** Document the specific indications, risks and alternatives that were explained to the patient. Note if patient provided written and/or verbal consent.
- **Pertinent Lab Values:** e.g. coags, CBC
- **Description of the procedure:** Describe prep, anesthesia, equipment used (e.g. suture type, needle size), and procedural technique.
- **Complications:**
- **EBL:** if appropriate
- **Disposition:** e.g. Pt tolerated the procedure well. Sutures to be removed by GP in 7 days.

Procedure Note - Example

- **Procedure:** Excisional Biopsy, L anterior shoulder
- **Performed by:** Sabrina Moore, MS2
- **Attending Physician:** Dr. Hui
- **Indications:** for pathologic diagnosis and to rule out malignancy of skin lesion with atypical features
- **Patient consent:** The indications for the procedure were discussed with the patient. Risks were discussed including infection, bleeding, or need for a second procedure if skin margins are considered inadequate. The patient provided verbal consent to proceed.
- **Pertinent Lab Values**: INR 1.0, Hb 140
- **Description of the procedure:** Skin cleaned with chlorhexidine and draped in sterile fashion. Local anesthesia achieved with 1% lidocaine with epinephrine x 2 cc. Skin lesion excised with elliptical incision and 0.5 mm margins. Wound closure achieved with 5 simple interrupted sutures using 4-0 Ethilon. Hemostasis achieved with sutures only.
- **Complications:** none
- **EBL:** minimal
- **Disposition:** Pt tolerated the procedure well. Pt to return to clinic for suture removal in 7 days.

TEAM ACTIVITY: SPECIFIC TYPES OF CLINICAL NOTES

Work in teams of 3-4 to develop a clinical note based on the case provided.
Then, have someone from your group present the case/note to the larger group.

Any questions about the following types of clinical notes?

- *Progress Notes (SOAP)*
- *OR Notes*
- *Delivery Notes*
- *Procedure Notes*

Summary of Key Points

- Notes should be clear and accurate
- Follow a basic structure for common clinical note types:
  - *Admission Note*
  - *ED Note*
  - *OR Note*
  - *Progress Note*
  - *Labour & Delivery Note*
- Use a template to help you, especially when you first start!