Notewriting Improvement Project - Grading Entry Form

Overall assessment

Overall rating of note
- ○ Below average
- ○ Average
- ○ Above average

Physician Documentation Quality Instrument-9 (PDQI-9)

PDQI-9-1. Up to date: The note contains the most recent test results and recommendations.
- ○ 1 (not at all)
- ○ 2
- ○ 3
- ○ 4
- ○ 5 (extremely)

PDQI-9-2. Accurate: The note is true. It is free of incorrect information.
- ○ 1 (not at all)
- ○ 2
- ○ 3
- ○ 4
- ○ 5 (extremely)

PDQI-9-3. Thorough: The note is complete and documents all of the issues of importance to the patient.
- ○ 1 (not at all)
- ○ 2
- ○ 3
- ○ 4
- ○ 5 (extremely)

PDQI-9-4. Useful: The note is extremely relevant, providing valuable information and/or analysis.
- ○ 1 (not at all)
- ○ 2
- ○ 3
- ○ 4
- ○ 5 (extremely)

PDQI-9-5. Organized: The note is well-formed and structured in a way that helps the reader understand the patient's clinical course.
- ○ 1 (not at all)
- ○ 2
- ○ 3
- ○ 4
- ○ 5 (extremely)

PDQI-9-6. Comprehensible: The note is clear, without ambiguity or sections that are difficult to understand.
- ○ 1 (not at all)
- ○ 2
- ○ 3
- ○ 4
- ○ 5 (extremely)

PDQI-9-7. Succinct: The note is brief, to the point, and without redundancy.
- ○ 1 (not at all)
- ○ 2
- ○ 3
- ○ 4
- ○ 5 (extremely)

PDQI-9-8. Synthesized: The note reflects the author's understanding of the patient's status and ability to develop a plan of care.
- ○ 1 (not at all)
- ○ 2
- ○ 3
- ○ 4
- ○ 5 (extremely)

PDQI-9-9. Internally Consistent: No part of the note ignores or contradicts any other part.
- ○ 1 (not at all)
- ○ 2
- ○ 3
- ○ 4
- ○ 5 (extremely)

ACGME Note writing checklist

1. Is PMD identified (name or has none)?
   ○ Yes
   ○ No

2. Are overnight events mentioned OR is there an acknowledgement that there were none?
   ○ Yes
   ○ No

3. Are the patient's complaints documented or is there an acknowledgement that there were none?
   ○ Yes
   ○ No

4. Is there a relevant and focused physical exam documented?
   ○ Yes
   ○ No

5. Have relevant lab values and studies been documented rather than pasting all information and have older studies been removed?
   ○ Yes
   ○ No

6. Have relevant lab values and studies been addressed in the problem-oriented assessment and plan?
   ○ Yes
   ○ No

7. Is there a prioritized and updated problem list?
   ○ Yes
   ○ No

8. Is there a global assessment of whether the patient is clinically the same, improving or worsening?
   ○ Yes
   ○ No

9. Is DVT prophylaxis (or reason why it is not required) documented?
   ○ Yes
   ○ No

10. Is code status documented?
   ○ Yes
   ○ No

11. Is there mention of a discharge plan, goals of hospitalization OR estimated length of stay?
   ○ Yes
   ○ No

12. Is the author's name listed at the bottom of the note?
   ○ Yes
   ○ No

13. Is the note copied and pasted from another physician's note?
   ○ Yes
   ○ No

14. Is the note concise yet adequately complete (no excessive copy and paste, no excessive repetition of data, no missing key information, etc)
   ○ Yes
   ○ No

For the post-intervention progress notes only: Was the new template used in this progress note?

○ Not applicable/this is a pre-intervention note.
○ Yes
○ No
○ Unsure

Appendix: Physician Documentation Quality Instrument (PDQI-9)

Date: __________ **Author:** ___________ **Reviewer:** ______________

Note Type (circle): Admit Progress Discharge

Instructions: Please review the chart before assessing the note. Then rate the note on each of the following attributes:

Attribute	Score					Description of Ideal Note
	Not at all				Extremely	
1. Up-to-date	1	2	3	4	5	The note contains the most recent test results and recommendations.
2. Accurate	1	2	3	4	5	The note is true. It is free of incorrect information.
3. Thorough	1	2	3	4	5	The note is complete and documents all of the issues of importance to the patient.
4. Useful	1	2	3	4	5	The note is extremely relevant, providing valuable information and/or analysis.
5. Organized	1	2	3	4	5	The note is well-formed and structured in a way that helps the reader understand the patient's clinical course.
6. Comprehensible	1	2	3	4	5	The note is clear, without ambiguity or sections that are difficult to understand.
7. Succinct	1	2	3	4	5	The note is brief, to the point, and without redundancy.
8. Synthesized	1	2	3	4	5	The note reflects the author's understanding of the patient's status and ability to develop a plan of care.
9. Internally Consistent	1	2	3	4	5	No part of the note ignores or contradicts any other part.
Total Score:						

(Version 1: 11/21/2011)

UCLA Progress Note Best Practices

Date Of Service, Hospital Day	Imported
PMD	Imported
Chief Complaint	Patient's own words. Changes to reflect daily CC
Overnight events	Significant and/or unexpected events
Subjective/ROS	Combine. Patient's own words re: how they are doing that day
Vital Signs	Range and current imported. 24 hour I/O. Weight typed in if relevant
Physical Exam	Updated daily. Focused, what was actually performed that day. Not a template
Labs	Pertinent and/or abnormal labs for that day. Not imported. Older results removed
Micro	New and pending. Older results removed
Studies	New. Reviewed by me. Key results in own words, not cut and pasted radiology report. Older studies removed
Assessment and Plan	Problem-based. Ordered by acuity with acute issues first, then chronic problems. Problems that are symptoms should be updated to diagnoses when determined. For each problem: status (stable, improving, worse), cause or DDx, workup planned or pending, plan. Clinical judgment re: which resolved problems to remove and which to move down to chronic/resolved problems section.
F/E/N L/T/D DVT ppx GI ppx Code Status Dispo	Imported. Lines, drains, tubes. Date placed. Indication
Medications	Not included in daily progress note given accessibility in EHR

Medicine Progress Note

PMD: @PCP@
DATE OF SERVICE: @TD@
HOSPITAL DAY: @LOS@
CC: @CHIEFCOMPLAINTN@

24 Hour Course/Overnight Events

***

Subjective/Review of Systems

***

Medications

@RRSCHEDIVMED@
PRNs: @MEDSPRN@

Infusions: @MEDSINFUSIONS@

Physical Exam

@VSRANGES@
I/O: @IOLAST2SHIFTS@
***

Data

{DATA:28470::"I have reviewed all of the labs from today. Pertinent labs include: ***"}

Problem-Based Assessment and Plan

@NAME@ is a @AGE@ @SEX@ ***
***

Inpatient Checklist
Diet: @RRDIET@
DVT Prophylaxis: {DVT PPX:28465}
GI Prophylaxis: {GI PPX:28466::"not indicated"}
Central Lines: {CENTRAL LINES:28468::"none"}
Tubes/Drains: {TUBES AND DRAINS:28469::"none"}
Disposition
***

Code Status
@RRCODESTATUS@,@RREMERCONTACT@

Author
@MECRED@
@TD@ at @NOW@

Embedded SmartLists

DATA:28470	1. I have reviewed all of the labs from today. Pertinent labs include: *** 2. I have reviewed all of the microbiology results from today. Pertinent microbiology results include: *** 3. I have reviewed all of the studies from today. Pertinent study results include: *** 4. I have reviewed the telemetry tracings. It showed *** 5. I have reviewed the electrocardiogram from today. It showed *** 6. There is no new data today
DVT PPX: 28465	1. Enoxaparin 2. Heparin subcutaneously 3. Fondaparinux 4. Warfarin 5. Sequential compression devices (SCDs) 6. Not indicated due to ***
GI PPX: 28466	1. Not indicated 2. Indicated due to patient is on chronic acid suppression therapy as an outpatient 3. Indicated due to coagulopathy (platelet count<50,000, INR>1.5, PTT>2x control 4. Indicated due to mechanical ventilation (likely for >48hours) 5. Indicated due to 2 or more minor risk factors: sepsis, ICU stay>1 week, occult GI bleeding >6 days, or high dose steroids 6. Indicated due to traumatic brain injury, spinal cord injury, or thermal injury 7. Indicated due to history of GI bleeding within the past year
GI PPX Type: 28467	1. H2 blocker 2. Proton pump inhibitor
Central Lines: 28468	1. None 2. Triple lumen catheter: Vein Central, Day*** 3. Hemodialysis catheter: Vein Central, Day*** 4. PICC (Day ***) 5. Tunneled catheter 6. Implanted port
Vein central: 12312	1. Internal jugular vein 2. Subclavian vein 3. Femoral vein 4. ***

Tubes AND Drains: 28469	1. None 2. Foley catheter (Day ****) 3. Nasogastric tube (Day ***) 4. Nasojejunal tube (Day ***) 5. Orogastric tube (Day ***) 6. Percutaneous gastric tube (Day ***) 7. Chest tube (Day ***) 8. JP drain (Day ***) 9. *** (Day ***)

University of California San Francisco (UCSF)
Division of Hospital Medicine Notewriting Taskforce
Best Practices

Progress Notes

General:
Daily progress notes should accurately and concisely document the patient care data and assessment and plan for each day of a patient's hospitalization. Attempts should be made to maximize note utility and to limit importing large data fields.

24 Hour Course/Overnight Events
Include a brief description of significant events of the last 24 hours. Examples of significant events include: major bleeding episode, acute agitation requiring intervention, transfer to a higher level of care, etc. This section should in general not include minor events such as consults, medication changes, basic tests, or routine parts of hospital care. Consider a bullet format.

Subjective/Review of Systems:
Document subjective complains and review of systems in the patients words. If the patient is unable to provide their subjective state, please document this.

Vitals:
Vitals will be automatically imported.

Intake/Output
Begins with a statement that "I have personally reviewed the Ins and Outs for today." There is then free text to enter a brief summary. This may be as simple as "positive 1 liter" or "even." If a patient has complex drains or atypical losses, please document these here as well (eg. chest tube output, NG tube output, etc.).

Physical Examination
Document only the components of the physical exam which were performed on this day. The physical examination should be updated daily. It can either be entered as free text or using the Notewriter Exam in EPIC.

Data
Do not import all available data and studies. Document labs, micro, and radiology that were pertinent to the care of the patient on this day (directly impacted management decisions). For EKG and/or telemetry (if available), briefly summarize the key findings.

Problem-based Assessment and Plan

Include a 1-2 line overall assessment of the patient which should be updated each day. The problem list should be prioritized each day. Problems which initially begin as symptoms should be updated to diagnoses once determined. For each problem, accurately and concisely describe the current status (stable, improving, worsening), the known cause or differential diagnoses, the diagnostic evaluation which has been or will be ordered, and the treatment plan. Problems which are resolved can be placed lower on the problem list by priority or can be officially resolved in the system.

Hospital Care

Accurately document the status of standard components of hospital care (to include but not be limited to DVT prophylaxis, fluids, diet, discharge planning, and code status). This section should be updated each day.

HOSPITAL MEDICINE PROGRESS NOTE

24 Hour Course/Overnight Events
***

Subjective/Review of Systems
***

Vitals
Temp:
Heart Rate
*Resp:
BP:
SpO2:

Intake/Output
I have reviewed the ins and outs for today. Summary: ***

Physical Exam

Data

{PERTINENT DATA REVIEWED:30420924::" "}

{I spoke with/Consult Requested:20929::" "}

Problem-based Assessment and Plan

XXM with…

No new assessment & plan notes have been filed since the last note was generated.

Inpatient Checklist
Foley day: {Foley Day:20869::"No Foley"}
DVT prophylaxis: {DVT PROPHYLAXIS:20846}
GI prophylaxis: {GI PROPHYLAXIS:20845}
Telemetry use: ***
Diet: {Diet Order:20870}
IV fluids: {IV Fluids:20871::"No IV Fluids"}
Access: {Access:20847}
Discharge planning: ***

Code Status Information

Code Status
Full Code

Scheduled Meds:

Continuous Infusions:

PRN Meds:

Bradley A Sharpe, MD
3/20/2015

IMPROVING RESIDENT NOTE QUALITY IN THE ERA OF THE EMR: A MULTI-INSTITUTIONAL COLLABORATION

APDIM SPRING MEETING 2015

Daniel Kahn, MD
Neveen El-Farra, MD
Wendy Simon, MD
Ed Lee, MD
Mark Duncan, MD
Jodi Friedman, MD
Michael Pfeffer, MD

Elizabeth Stewart, MD
Bradley Sharpe, MD
Andrew Lai, MD
Stephanie Rennke, MD
Aylin Ulku, MD
Sanjay Reddy, MD
Faye Chan, MD
Ethel Wu, MD

Katherine Harris, MD
Hilary Mosher, MD
Justin Smock, MD
Scott Wilson, DO
Samantha Danielson, MD
Roberto Leon-Farre, MD
Ethan Kuperman, MD
Jessica Cyr, MD
Russell Leslie, MHA

John Bell, MD MPH
Meghan Sebaskey, MD
Courtney O'Rourke, DO
Jessica Bazick, MD

Roadmap

- Background
- Perceptions of Note Quality
- Best Practices/Intervention
- Take-Home

Goals

- Appreciate it is possible to develop "best practices" for note writing
- Recognize validated tools for assessing note quality
- Describe how a template and educational intervention can improve note quality

Roadmap

- **Background**
- Perceptions of Note Quality
- Best Practices/Intervention
- Take-Home

Background: The Note

There were exacerbations of the fever; the bowels passed practically nothing of the food taken; the urine was thin and scanty. No sleep. About the fourteenth day from taking to bed, after a rigor, he grew hot; wildly delirious, shouting, distress, much rambling, followed by calm. The coma came at this time.

Thirty-fourth day. Death.

-- 5th Century BC

vs stbl, ō comp.; no Δ resp. - 02 sats ok; xam un-Δ'd - see note 11/12; fam. visit.; no nursing issues; labs = no incr. aldolase, CK's; note: this enctr. took 65' & inv. a hi deg. of compex. in dec. making.

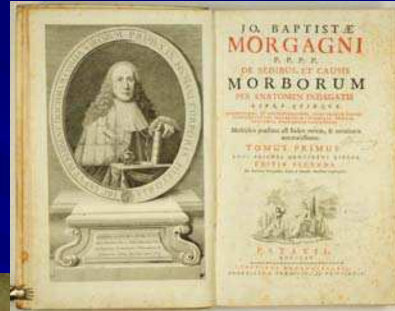
Background: The Note

There were exacerbations of the fever; the bowels passed practically nothing of the food taken; the urine was thin and scanty. No sleep. About the fourteenth day from taking to bed, after a rigor, he grew hot; wildly delirious, shouting, distress, much rambling, followed by calm. The coma came at this time.

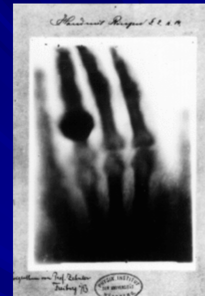
-- 5th Century BC

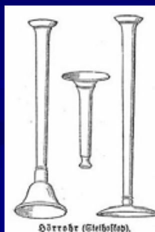
Aphorismi
HIPPOCRATIS
Græce & Latine:
JUXTA
Optimam Editionem
THEODORI JANSSONII ab
Almeloveen, Med. Doct.

Clinicopathologic Correlation (1761)

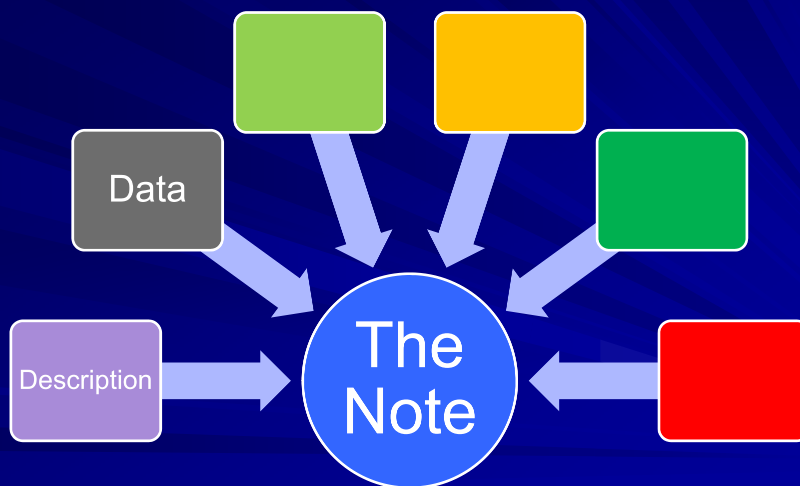


Information/Data (1816)

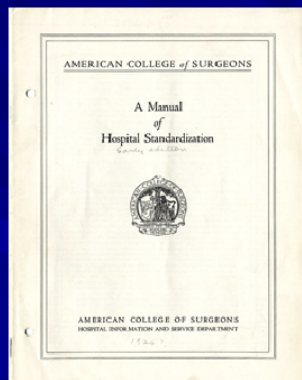




Medical Note



Research/Quality (1800-1900s)

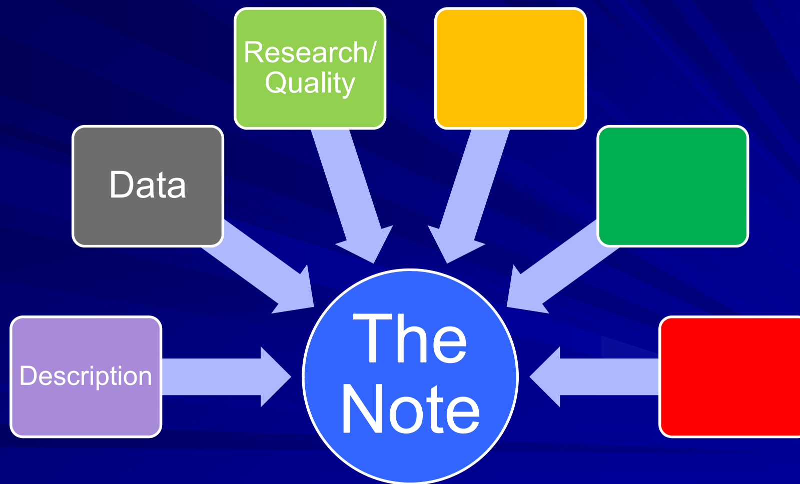


AMERICAN COLLEGE of SURGEONS

A Manual
of
Hospital Standardization

AMERICAN COLLEGE OF SURGEONS
HOSPITAL INFORMATION AND SERVICE DEPARTMENT

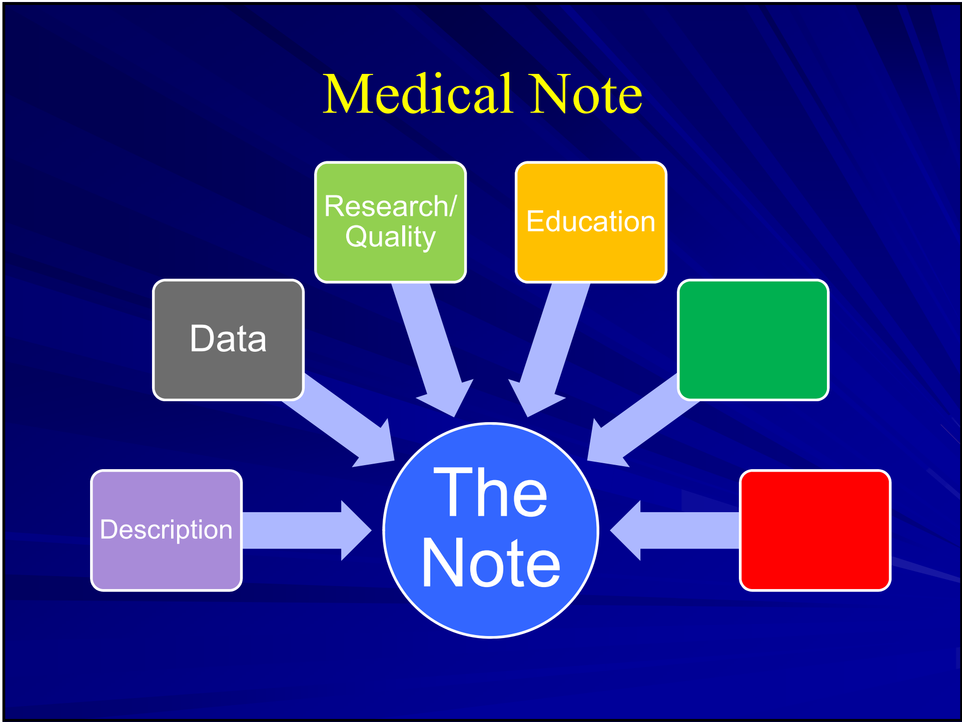
Medical Note

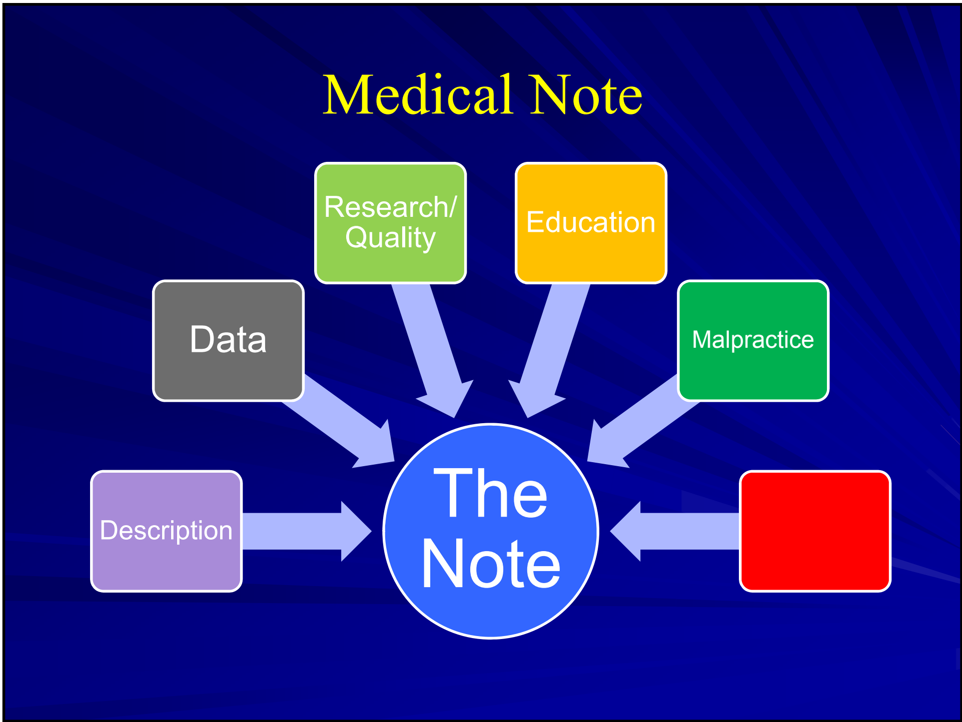


Education (1800-1900s)

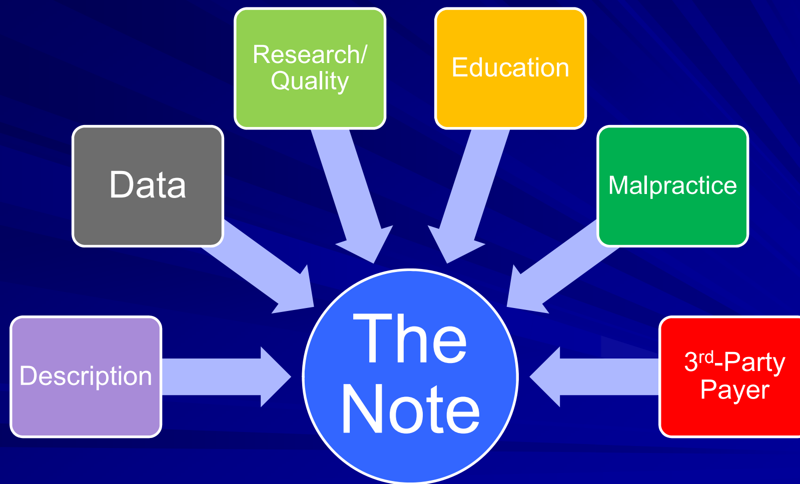
The house-physician, under direction of the attending physician, shall keep a register of all medical cases which occur in the hospital, and which the latter shall think worthy of preservation….

-- *New York Hospital 1805*


Medical Note
Research/
Quality
Education
Data
Description
The
Note

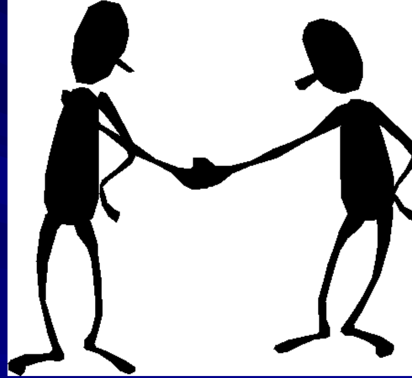

Medical Note
Research/
Quality
Education
Data
Malpractice
Description
The
Note

Medical Note



Electronic Health Record

Current Notes



State of the Evidence

- Very little robust research – most opinion and thought pieces

Off the Record — Avoiding the Pitfalls of Going Electronic

Pamela Hartzband, M.D., and Jerome Groopman, M.D.

Many of us remember search- ... istration, the presidential candi- ... lected in one place and available at a single keystroke. And there is

A PIECE OF MY MIND

Copy-and-Paste

THE ELECTRONIC MEDICAL RECORD (EMR) ARRIVED AT our teaching hospital one year ago and the resultant changes in medical student and physician notes have been remarkable. While EMR is highly efficient in producing notes, virtually all of its notes are longer, recombinant versions of previous notes. Even notes of different authors are morphed by EMR into clones of one another. As physicians have become more adept with the time-saving features of EMR, ...

A PIECE OF MY MIND

John Lennon's Elbow

THE ELECTRONIC MEDICAL RECORD (EMR) HAS TRANSformed the nature and purpose of hospital progress notes. While copy-and-paste has played a dominant ... ough, and unreadable. Unreadability is a problem only if readability is a goal. But these notes are not constructed to be read. They are constructed to warehouse data. All the key

State of the Evidence

- Very little robust research – most opinion and thought pieces
- Identified common themes:
  - "Bloated notes"
  - Incorrect/outdated information
  - Extra information
  - Focus on billing
  - Less clinical reasoning

Hartzband P, et al. *NEJM.* 2008
Sheehy AM, et al. *JAMA Intern Med.* 2014
Hirschtick RE. *JAMA.* 2012

EHR in the News

Home / The Daily Briefing / April 2, 2015 | The Daily Briefing / Joint Commission issues sentinel alert over EHR risk

Daily Briefing   View the Archives   Print Today's Stories

Joint Commission issues sentinel alert over EHR risks

Although EHRs can do a lot of good, the technology poses inherent risks, group warns

10:09 AM - April 2, 2015

The Joint Commission on Tuesday issued a sentinel event alert, warning that while electronic health records (EHRs) and other health IT have the potential to improve care quality and safety, such technologies can pose inherent risks to patients.

Details of alert

Latest from the Daily Briefing

FEATURED
15 ways to solve nurses' biggest engagement challenges
12:06 PM - April 10, 2015

Report: 2014-2019 health spending estimate down by 11%
10:17 AM - April 10, 2015

Study: Popular diet supplements contain amphetamine-like chemical
10:14 AM - April 10, 2015

Walgreens will close 200 stores
9:53 AM - April 10, 2015

Six months later: VA hospitals still struggling to improve wait times

Roadmap

- Background
- Perceptions of Note Quality
- Best Practices/Intervention
- Take-Home

Attending and Housestaff Perceptions of Progress Notes

- Developed Survey
  - PDQI-9
  - ACGME Competency Note Checklist
  - Questions generated by core faculty

Appendix: Physician Documentation Quality Instrument (PDQI-9)

Date: _________ **Author:** __________ **Reviewer:** _____________

Note Type (circle): Admit Progress Discharge

Instructions: Please review the chart before assessing the note. Then rate the note on each of the following attributes:

Attribute	Score	Description of Ideal Note
1. Up-to-date	Not at all 1 2 3 4 5 Extremely	The note contains the most recent test results and recommendations.
2. Accurate	Not at all 1 2 3 4 5 Extremely	The note is true. It is free of incorrect information.
3. Thorough	Not at all 1 2 3 4 5 Extremely	The note is complete and documents all of the issues of importance to the patient.
4. Useful	Not at all 1 2 3 4 5 Extremely	The note is extremely relevant, providing valuable information and/or analysis.
5. Organized	Not at all 1 2 3 4 5 Extremely	The note is well-formed and structured in a way that helps the reader understand the patient's clinical course.
6. Comprehensible	Not at all 1 2 3 4 5 Extremely	The note is clear, without ambiguity or sections that are difficult to understand.
7. Succinct	Not at all 1 2 3 4 5 Extremely	The note is brief, to the point, and without redundancy.
8. Synthesized	Not at all 1 2 3 4 5 Extremely	The note reflects the author's understanding of the patient's status and ability to develop a plan of care.
9. Internally Consistent	Not at all 1 2 3 4 5 Extremely	No part of the note ignores or contradicts any other part.
Total Score:		

Copy-Forward/Autopopulation

14) Copy forward (i.e. data from one note imported into a new note) has the following impact on my critical thinking about patient care

- ○ Very negative
- ○ Somewhat negative
- ○ Neutral
- ○ Somewhat positive
- ○ Very positive

15) Copy forward has the following impact on the accuracy of my notes

- ○ Very negative
- ○ Somewhat negative
- ○ Neutral
- ○ Somewhat positive
- ○ Very positive

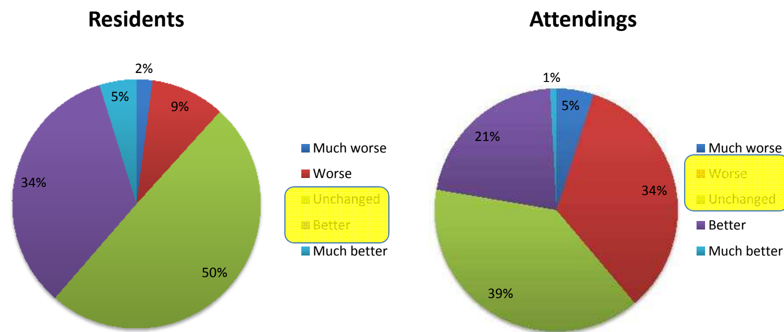
16) Copy forward has the following impact on accurately prioritizing my daily problem list

- ○ Very negative
- ○ Somewhat negative
- ○ Neutral
- ○ Somewhat positive
- ○ Very positive

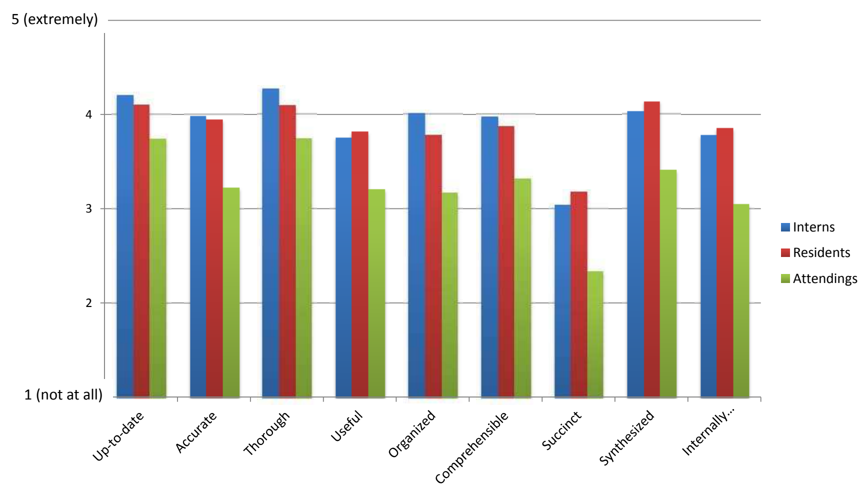
17) Autopopulation (i.e. stored data imported into the note from smart phrases) has the following impact on my critical thinking about patient care

- ○ Very negative
- ○ Somewhat negative
- ○ Neutral
- ○ Somewhat positive
- ○ Very positive

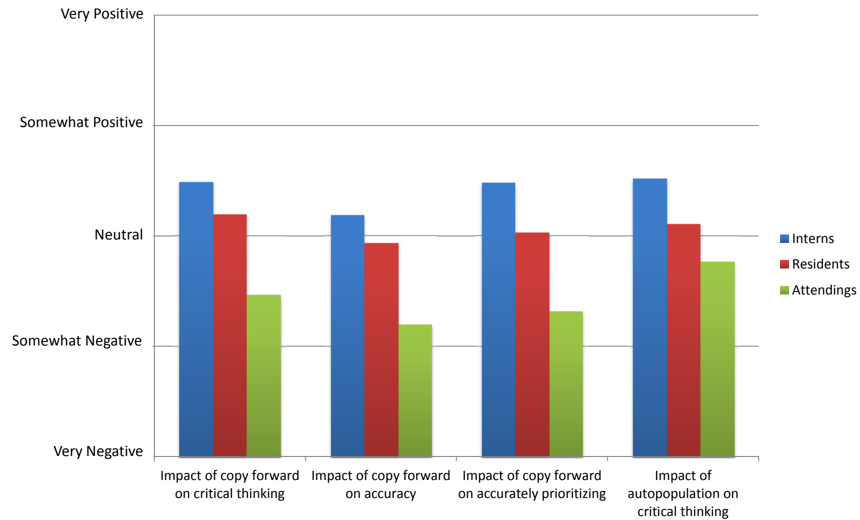
Since adopting an EHR, Note Quality is…



Perception of PDQI-9 Domains



Copy Forward/Autopopulation



Roadmap

- Background
- Perceptions of Note Quality
- Best Practices/Intervention
- Take-Home

Best Practices

- 10 Clinician Educators at UCLA
- 10 Clinician Educators at UCSF

UCLA

Date Of Service, Hospital Day	Imported
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Studies	New. Reviewed by me. Key results in own words, not cut and pasted radiology report. Older studies removed
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F/E/N L/T/D DVT ppx GI ppx Code Status Dispo	Imported. Lines, drains, tubes. Date placed. Indication
Medications	Not included in daily progress note given accessibility in EHR

UCSF

General	Accurately and concisely document the patient care data and assessment and plan. Maximize note utility, limit importing large data fields
24 Hour Course/Overnight Events	Significant events, exclude minor events
Chief Complaint	Not included
Subjective/ROS	Combine. Patient's own words. Document if pt unable to provide subjective
Vital Signs	Imported
Intake/output	I have reviewed… Free text. Document complex losses/drains
Physical Exam	Updated daily. Focused, what was actually performed that day. Free text or notewriter exam in EPIC
Data	Pertinent to care on this day. Do not import all data/studies
Problem-based Assessment and Plan	Brief assessment. Updated, prioritized daily. Symptoms updated to diagnoses. Status, cause or Ddx, evaluation, treatment documented. Resolved problems can be placed lower or can be officially resolved
Hospital Care	DVT, Fluids, diet, dispo, code. Accurate, updated daily
Medications	Not included in daily progress note given accessibility in EHR

The Template

Medicine Progress Note

PMD: @PCP@
DATE OF SERVICE: @TD@
HOSPITAL DAY: @LOS@
CC: @CHIEFCOMPLAINTN@

24 Hour Course/Overnight Events
***

Subjective/Review of Systems
***

Medications
@RRSCHEDIVMED@
PRNs: @MEDSPRN@

Infusions: @MEDSINFUSIONS@

Physical Exam
@VSRANGES@
I/O: @IOLAST2SHIFTS@
***

Data
{DATA:28470::"I have reviewed all of the labs from today. Pertinent labs include: ***"}

Problem-Based Assessment and Plan

@NAME@ is a @AGE@ @SEX@ ***
***

Inpatient Checklist
Diet: @RRDIET@
DVT Prophylaxis: {DVT PPX:28465}
GI Prophylaxis: {GI PPX:28466::"not indicated"}
Central Lines: {CENTRAL LINES:28468::"none"}
Tubes/Drains: {TUBES AND DRAINS:28469::"none"}
Disposition
***

Code Status
@RRCODESTATUS@,@RREMERCONTACT@

Author
@MECRED@
@TD@ at @NOW@

Resident Buy In

- Meeting open to all
  - With Pizza!
  - Chiefs and Residents in Attendance
- Focus on quality improvement over style
- Issues raised

Confidential

Notewriting Improvement Project - Grading Entry Form

Overall assessment

Overall rating of note	○ Below average ○ Average ○ Above average

Physician Documentation Quality Instrument-9 (PDQI-9)

PDQI-9-1. Up to date: The note contains the most recent test results and recommendations.	○ 1 (not at all) ○ 2 ○ 3 ○ 4 ○ 5 (extremely)
PDQI-9-2. Accurate: The note is true. It is free of incorrect information.	○ 1 (not at all) ○ 2 ○ 3 ○ 4 ○ 5 (extremely)
PDQI-9-3. Thorough: The note is complete and documents all of the issues of importance to the patient.	○ 1 (not at all) ○ 2 ○ 3 ○ 4 ○ 5 (extremely)
PDQI-9-4. Useful: The note is extremely relevant, providing valuable information and/or analysis.	○ 1 (not at all) ○ 2 ○ 3 ○ 4 ○ 5 (extremely)
PDQI-9-5. Organized: The note is well-formed and structured in a way that helps the reader understand the patient's clinical course.	○ 1 (not at all) ○ 2 ○ 3 ○ 4 ○ 5 (extremely)
PDQI-9-6. Comprehensible: The note is clear, without ambiguity or sections that are difficult to understand.	○ 1 (not at all) ○ 2 ○ 3 ○ 4 ○ 5 (extremely)
PDQI-9-7. Succinct: The note is brief, to the point, and without redundancy.	○ 1 (not at all) ○ 2 ○ 3 ○ 4 ○ 5 (extremely)
PDQI-9-8. Synthesized: The note reflects the author's understanding of the patient's status and ability to develop a plan of care.	○ 1 (not at all) ○ 2 ○ 3 ○ 4 ○ 5 (extremely)
PDQI-9-9. Internally Consistent: No part of the note ignores or contradicts any other part.	○ 1 (not at all) ○ 2 ○ 3 ○ 4 ○ 5 (extremely)

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ACGME Note writing checklist

1. Is PMD identified (name or has none)?	○Yes ○No
2. Are overnight events mentioned OR is there an acknowledgement that there were none?	○ Yes ○ No
3. Are the patient's complaints documented or is there an acknowledgement that there were none?	○ Yes ○ No
4. Is there a relevant and focused physical exam documented?	○ Yes ○ No
5. Have relevant lab values and studies been documented rather than pasting all information and have older studies been removed?	○ Yes ○ No
6. Have relevant lab values and studies been addressed in the problem-oriented assessment and plan?	○ Yes ○ No
7. Is there a prioritized and updated problem list?	○Yes ○No
8. Is there a global assessment of whether the patient is clinically the same, improving or worsening?	○ Yes ○ No
9. Is DVT prophylaxis (or reason why it is not required) documented?	○ Yes ○ No
10. Is code status documented?	○ Yes ○ No
11. Is there mention of a discharge plan, goals of hospitalization OR estimated length of stay?	○ Yes ○ No
12. Is the author's name listed at the bottom of the note?	○ Yes ○ No
13. Is the note copied and pasted from another physician's note?	○ Yes ○ No
14. Is the note concise yet adequately complete (no excessive copy and paste, no excessive repetition of data, no missing key information, etc)	○ Yes ○ No

For the post-intervention progress notes only: Was the new template used in this progress note?	○ Not applicable/this is a pre-intervention note. ○ Yes ○ No ○ Unsure

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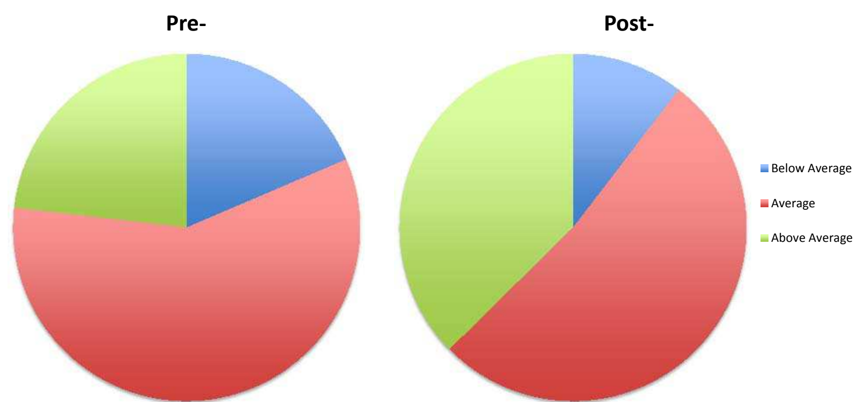
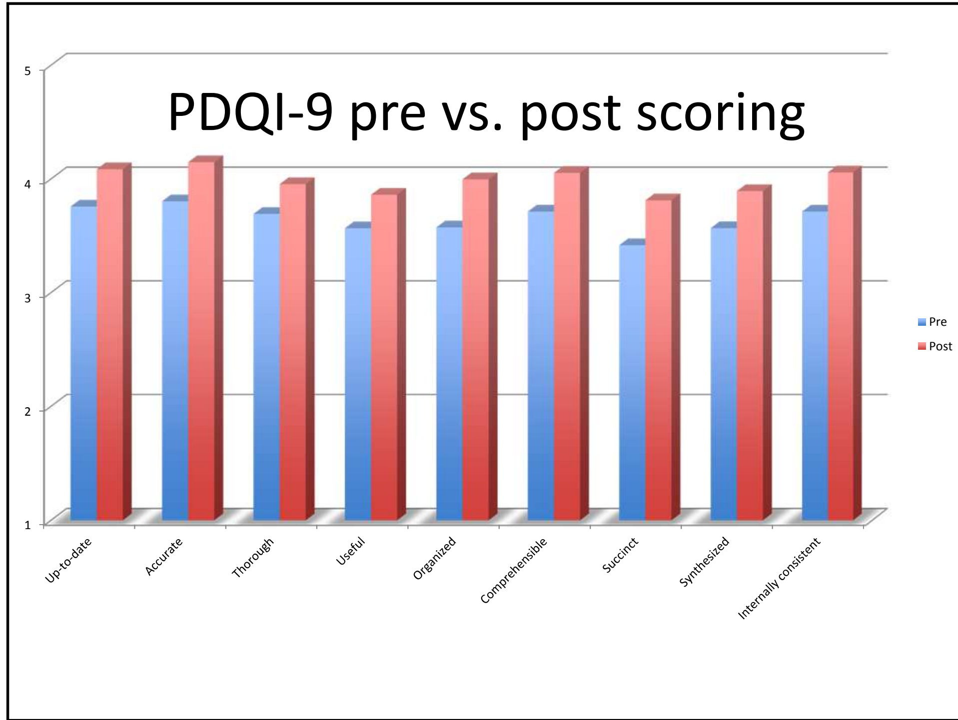
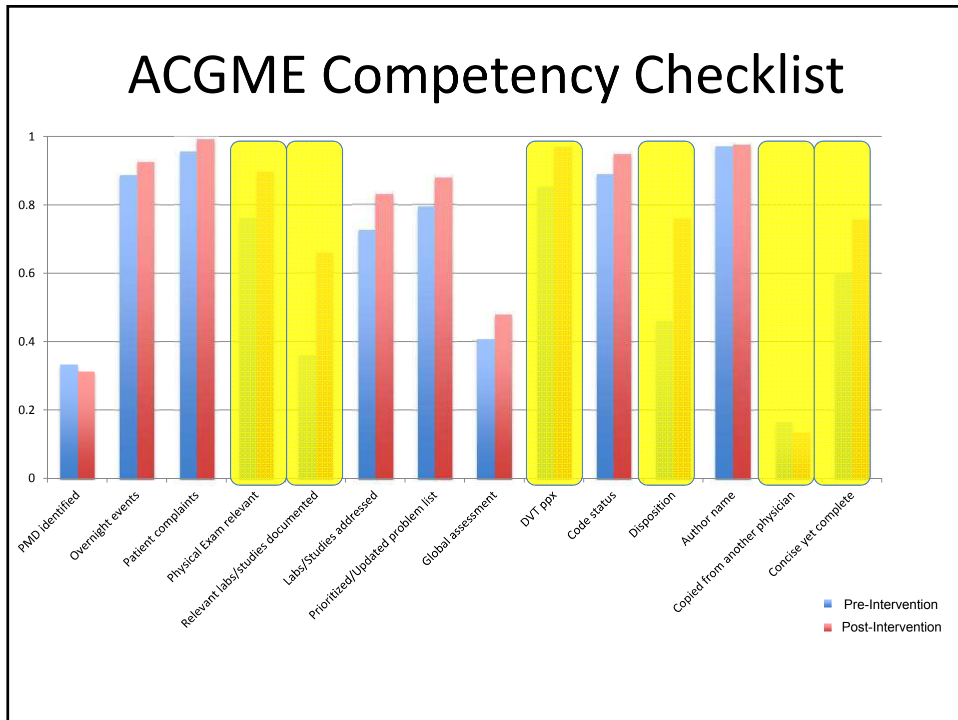
So did it work?

Overall Note Quality




PDQI-9 pre vs. post scoring
5
4
3
2
1
Up-to-date
Accurate
Thorough
Useful
Organized
Comprehensible
Succinct
Synthesized
Internally consistent
Pre
Post


ACGME Competency Checklist
1
0.8
0.6
0.4
0.2
0
PMD identified
Overnight events
Patient complaints
Physical Exam relevant
Relevant labs/studies documented
Labs/Studies addressed
Prioritized/Updated problem list
Global assessment
DVT ppx
Code status
Disposition
Author name
Copied from another physician
Concise yet complete
Pre-Intervention
Post-Intervention

Pre Template Note

Basename	05/12/14 0625	05/11/14 0600	05/10/14 0700
WBC	7.34	9.64	7.45
NEUTABS	6.3	8.5*	6.4
HGB	8.7*	8.8*	8.9*
HCT	25.3*	25.1*	25.4*
MCV	89.1	87.5	87.6
PLT	111*	124*	111*

BMP

Recent Labs

Basename	05/12/14 0625	05/11/14 1550	05/11/14 0810	05/11/14 0600	05/10/14 0700
NA	137	--	--	136	134*
K	4.6	5.8*	5.8*	5.7*	5.1
CL	111*	--	--	110*	108
CO2	22	--	--	21	22
BUN	13	--	--	9	8
CREAT	1.0	--	--	1.0	1.1
CALCIUM	8.4*	--	--	9.1	8.7
MG	1.1*	--	--	1.2*	1.3
PHOS	3.5	--	--	2.5	2.4

LFTs

No results found for this basename: TOTPRO:8,ALBUMIN:8,BILITOT:8,BILICON:8,ALT:8,AST:8,ALKPHOS:8,GGT:8,AMYLASE:8,LIPASE:8 in the last 72 hours

Coags

No results found for this basename: INR:8,PT:8,APTT:8 in the last 72 hours

Glucose

Recent Labs

Basename	05/12/14 1216	05/11/14 2130	05/11/14 1423	05/11/14 0832	05/11/14 0032	05/10/14 2158	05/10/14 1853	05/10/14 1349	05/10/14 0713	05/09/14 2244
GLUCOSEPOC	161*	214*	142*	80	181*	260*	153*	246*	198*	356*

Microbiology:

Blood Cultures

Bact Culture Blood

Date	Value	Range	Status
5/11/2014	NEGATIVE TO DATE TO OPTIMIZE ORGANISM RECOVERY (90-99%), SUBMIT 2		Preliminary

Post Template Note

Medicine Progress Note

PMD: ████, MD
DATE OF SERVICE: 1/23/2015
HOSPITAL DAY: 2
CHIEF COMPLAINT: Abdominal Pain

Last 24 Hour/Overnight Events:
None

Subjective/Review of Systems:
Abdominal pain remains an 8. After dilaudid decreases to a 5 for an hour and then starts worsening. No appetite. Denies fever, SOB, nausea. No BM.

Medications:
Scheduled:

amlodipine	10 mg	Oral	Daily
docusate	100 mg	Oral	BID
escitalopram	10 mg	Oral	Daily
losartan	50 mg	Oral	Daily
pantoprazole	40 mg	Oral	Daily
polyethylene glycol	17 g	Oral	Daily

PRN:
hydrocodone-acetaminophen, hydromorphone, lorazepam, metoclopramide, simethicone
Infusions:

sodium chloride	100 mL/hr (01/23/15 0205)

Physical Exam:
Temp: [36.8 °C (98.2 °F)-37.3 °C (99.2 °F)] 37.3 °C (99.2 °F)
Heart Rate: [81-97] 83
Resp: [16-24] 20
BP: (146-164)/(65-74) 164/74 mmHg
NBP Mean: [88-104] 101
SpO2: [93 %-98 %] 97 %
I/O: I/O last 2 completed shifts:
In: 3104.2 [I.V.:3104.2]
Out: 150 [Urine:150]
Const: NAD, obese
Eyes: Sclerae anicteric
ENMT: No oral lesions, dry MM
CV: RRR, no murmurs, no edema
Resp: CTAB, no accessory muscle use
GI: TTP diffusely most severe epigastrium and RUQ. Some guarding without rebound. +bowel sounds.
Skin: No rashes or nodules

Data:
I have reviewed all of the labs from today. Pertinent labs include:
WBC 6.9 Hgb 10.5 Plt 274
Na 137 K 3.9 Cr 0.6 Ca 8.8
LFTs: Improving

Problem-Based Assessment and Plan:

████ is a █ y.o. ████ h/o chronic abdominal pain, depression/anxiety, GERD, spinal stenosis on chronic narcotics presents s/p ERCP for post ERCP pancreatitis.

#Pancreatitis. Improving.
-Pain control, IVF, monitor electrolytes
-Slowly advance diet as tolerated
-Increase dilaudid to 1.5mg IV Q3 from Q4 for better pain control

#Elevated LFTs. Pt with prior negative work up in the past. Likely 2/2 procedure. Improving
-Continue to monitor. Daily LFTs for now

#Chronic abdominal pain. Now s/p ERCP with failed CBD stent placement.
-Monitor. f/u with GI after resolution of pancreatitis.

#Spinal stenosis
-Pt takes vicodin, oral dilaudid at home
-Discussed alternative therapy such as East West, PT

#Anemia, normocytic. Stable. Defer work up to outpt

#Constipation. Continue bowel regimen

#Depression. Stable. Continue Lexapro

#HTN. Amlodipine, losartan

Inpatient Checklist

Diet:
Diet clear liquid
DVT Prophylaxis: not indicated due to Ambulating and anticipate short length of stay
GI Prophylaxis: indicated due to patient is on chronic acid suppression therapy as an outpatient: Proton pump inhibitor
Central Lines: none
Tubes/Drains: none

Disposition
Home once pain controlled on oral narcotics and tolerating diet. Estimated DC 1/24

Code Status
Full Code, Primary Emergency Contact: ████

Author
████, MD
1/23/2015 at 11:06 AM

Roadmap

- Background
- Perceptions of Note Quality
- Best Practices/Intervention
- Take-Home

Keys to successful implementation

- Accessibility
- Educational lead in
- Resident Collaboration
- Usability
- Continuous feedback
- Reminders

Goals for Home

- Note assessment instruments
- Obtain resident buy in
- Implement a template

Thank You

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