In Search of the Holy Grail: How to Ensure the Perfect Progress Note

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Why are Progress Notes a Problem?

- Electronic medical record! (notes fell apart in our program after the EMR)
- Cut and paste (UPMC cardiologist)
- Too long and too wordy
- Too much fluff (each of 4 CXR's listed)
- Not updated
- Lack assessment/clinical reasoning
  - Not helpful for consultants
  - Not helpful for cross-covering housestaff

Why are Progress Notes a Problem?

- Non-committal ("to consider . . .")
- Errors: "Plan for OR tomorrow . . . Post-op day 3 s/p cholycystectomy"
- Low priority for interns ("No one ever died of note-apenia")
- Timing: end of day
- EMR may be a huge part of the cause, but it's here to stay

What Progress Notes Are NOT

- Complete summary of the hospital course until this point in time
  - Reads like a diary
  - "On hospital day 1 . . . hospital day 2, patient . . ."
- Regurgitation of all diagnostic tests with no assessment or synthesis
  - Advantage of the EMR: report of all tests is readily available for anyone to review

Goals of Progress Notes

- Document the day's events
  - Patient status
  - Pertinent and *changing* physical examination
  - Pertinent labs/studies
- Communication of information
  - For consultants
  - For cross cover
- Medical-legal documentation
- A good progress note drives a good presentation

How can we fix progress notes?

How can we ensure we get what we want?

SSOOAP (SOAP 2.0)

- Summary Statement
- Subjective
- Objective #1: 24 hour events
- Objective #2: Vitals, Pertinent Pex & New data
- Assessment
- Plan

Beginning a Progress Note: Summary Statement

- **First line**: Summarizes reason for admission
  - 3-5 key pieces of data that will drive differential diagnosis/clinical decision-making
  - "50 yo male with a history of HIV infection, recent CD4 count 150, and alcohol use admitted with increasing confusion without focal neurologic deficits."
- May be copied BUT needs to be tailored as course changes
  - After the MRI, the summary statement becomes:
  - "50 yo male with HIV infection admitted with confusion secondary to progressive multifocal leukoencephalopathy"

Subjective

- Start with how the patient is the day that the note is being written
  - "This a.m. patient is resting comfortably. He denies any chest pain, sob, or wheezing"
  - Brief pertinent positives and negatives
- With complicated patients, may need to organize by problems (which should reflect your problem list in the assessment)
  - Confusion: Remains agitated, no significant change
  - Pneumonia: No cough or sputum. No c/o SOB
  - GI Bleeding: No further hematemesis or BRBPR

Objective #1: 24 Hour Events

- Test results obtained: "CXR overnight showed. . ."
- Cultures updated
- Cross-coverage intervention: "NF called for fever, resent cultures, no antibiotics started."
- Consultants' recs: include under problem list
  - Confusion: Remains agitated, no significant change from admission
  - Pneumonia: No cough or sputum. No c/o SOB
  - GI Bleeding: No further hematemesis or BRBPR. Seen by GI, they recommend EGD . . ."

Objective #2: Physical Exam

- Physical exam
  - Need to update daily from admission exam
  - No one believes a full cranial nerve exam was done on a patient admitted for CHF 4 days ago
- Should include not only the "check box" pertinent positives but also *pertinent negatives*
  - For patient with cirrhosis and mental status changes
    - General neuro exam (check boxes)
    - Specify: "no asterixis"

Objective #2: New Data (Labs/Imaging)

- Cut and paste of labs and X-rays: waste of time
- Hard to read
- Fails to hone in on most important data
- NO ONE goes to progress notes with the goal of reviewing all labs/images
- Tailoring data reported allows for data synthesis
  - Ex: report H and H; not the entire profile
  - Ex: report CXR has no infiltrate, not the entire report from start to finish

Assessment

- Most important part of the note
- Should not repeat the summary statement
- Should be NEW and UPDATED every day
- Incorporate assessment into each problem
- List problems in decreasing order of importance

Assessment

- Each problem should be followed by discussion
  - What intern thinks is going on and why
  - Discusses things that don't fit
  - Lists differential in order of likelihood, explains why
  - Written in paragraphs, not bullets
- Not necessary to include all stable problems
  - Ex: "Hypertension: stable, no issues" (who cares unless BP is elevated and requires active management!)
- Disposition and prophylaxis always help keep on track

Plan

- Requires a commitment
- Should be specific
  - What antibiotics
  - How many days
  - How will response be monitored
- Avoid "to consider"; make instead an if/then statement
- Each problem should have a separate plan

Plan

- Plan should communicate what intern is doing that day/that admission/planning for follow up
- Does not need to address/justify every chronic medication the patient is on
- What questions will consultants be asked?
- What issues are troubling and what is the plan for answering ongoing questions?
- Should not include issues that are resolved (Ex: Patient on hospital day 5 for hepatic encephalopathy with AKI on admission that resolved with 24 hours of fluids)

Summary

- A good progress note is:
  - Focused
  - Well-organized
  - Specific
  - Updated daily
  - Clear in the assessment and plan for each problem
  - User friendly
- Achieving good progress notes requires monitoring, frequent feedback, and a plan for implementation within a residency

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Progress note #1

Background: Pt is a 73 yo gentleman with hx of multiple small and large bowel angiodysplastic lesions, oxygen dependent COPD who presented from outpatient clinic with SOB and Hemoglobin of 7.2. This note was written by an intern on hospital day #4 (8/20/11).

S: Mr. Smith had no acute events overnight. This morning, he was sitting up in his bedside eating breakfast without complaints. Comfortable on 3L of oxygen. He just had BM in his bedside commode, which was well formed, solid and brown in color. He denies any bloody or black BMs overnight. He reported that by walking over to bedside commode and back to bed makes him short of breath and at baseline he is able to walk further without getting SOB. Yesterday, due to acute SOB in the morning and fact that he had not been on heparin PPX for GI bleed, a CT with PE protocol was done which did not show any PE.

Active Inpatient Medications (excluding Supplies):

Active Inpatient Medications	Status
1) ALBUTEROL 0.083% INHL 3ML NEBS SOLN,INHL 1 DOSETTE	ACTIVE INH NEB Q4H VIA AEROSOL NEBULIZER
2) CALCIUM CARBONATE 500MG/VITAMIN D 200 1 TABLET PO	ACTIVE TID
3) FERROUS SULFATE TAB 650MG PO TID	ACTIVE
4) HYDROCHLOROTHIAZIDE TAB 12.5MG PO QDAY	ACTIVE
5) IPRATROPIUM 0.02% SOLN,INHL 1 DOSETTE INH NEB Q4H	
6) MOMETASONE **ORAL** INHL,ORAL 2 PUFFS PO QPM5	
7) PANTOPRAZOLE INJ,PWDR 40MG IVP Q12H RECONSTITUTE	ACTIVE WITH 10ML NSS. GIVE IVP OVER 2 MINUTES. FOR 7 DAYS
8) SIMVASTATIN TAB 40MG PO QPM5	
9) TEMAZEPAM CAP,ORAL 7.5MG PO QHS	

O: PULSE: 91 8/20/11 @ 0816
BLOOD PRESSURE: 132/61 8/20/11 @ 0816
TEMPERATURE: 97.4 8/20/11 @ 0816
RESPIRATION: 16 8/20/11 @ 0816
Gen: NAD, comfortable, pale
HEENT: NCAT, PERRL
Lungs: bibasilar crackles, No wheezing, rales or rhonchi
Heart: RRR, no murmur, rubs or gallop
Abd: soft, non-tender, non-distended, no mass, no hepatosplenomegaly
Ext: No edema, cyanosis or clubbing
Neuro: A + O x3, CN II-XII grossly intact, no focal neurological deficits

A/P:
72 y/o M w/Hx of numerous angiodysplastic lesions in his small bowels and chronic occult GI bleeding s/p 2 units of pRBCs, underwent capsule endoscopy on 8/18.

Chronic Anemia and iron deficiency 2/2 GIB s/p 2 units pRBCs, Patient had two previous admissions in May and June for symptomatic anemia and GI noted that serial blood transfusions were the only option for repeated GIBs that can occur secondary to hundreds of angiodysplastic lesions that can bleed spontaneously.
- Will check H&H daily and increase the frequency if he starts to have melena or hematochezia.
- Per oral report from GI, there are several non-bleeding AVM in his small bowels, recommend continuing current therapy and H/H once every 2 weeks by discharge.
- Change to PO protonix BID
- iron panel continues to show iron deficiency despite transfusion few days ago.
- Restart iron 650mg ferrous sulfate TID
- Heme recommended outpatient IV iron infusion.

SOB and significant DOE from baseline
-Pt has poor reserve due to COPD and Hx of Vascular disease (AAA repair)
-EKG was unremarkable and unchanged from previous ones
-Will transfuse him 1 units to see how he responded breathing wise

-May repeat ECHO, last ECHO in 2000 showed normal EF, no wall motion abnormalities. If his breathing dose not improve with transfusion, will re-evaluate his cardiac function by ECHO.
-Possible deconditioning due to lack of PT during hospitalizations
-Home exercise oxygen eval and Nebulizing training on Monday.
-Could potentially be worsening of his COPD, will follow up with outpatient PFT, last once was in 1998.

Baseline COPD with a 3L/min NC O2 req
- Continue 3L/min NC O2
- Continue home mometasone, ipratropium, and albuterol Tx

Hypertension & Hyperlipidemia:
The patient claims that he does not take any medications at home for hypertension or hyperlipidemia, but his outpatient medications do include HCTZ and simvastatin
- Resume home dose HCTZ 12.5mg and simvastatin 40mg daily

Prophylaxis:
- subQ heparin now he does not appear to be bleeding and H/H has been stable.

Progress note #2

Background: This patient is a pleasant 91 yo gentleman with hx of bullous pemphigoid on high-dose steroids and frequent hospitalizations who presented from home with tachycardia to the 140s and cough. Initially treated for hospital acquired pneumonia and urinary tract infection but after 2 days of persistent tachycardia a CT scan was done and patient was found to have a small PE. Anticoagulation was started but patient developed anemia, thrombocytopenia and guaiac + stools (no frank GI bleed). Anticoagulation was stopped and IVC filter was considered. This progress note was written on HD #6 by the intern.

S: no acute events o/n. Was able to reach pt's son by phone this am, and after outlining plan of care and the patient's options, he did opt for placement of a IVC filter.

O:

	VITAL SIGNS					
DATE/TIME	TEMP	PULSE	RESP	BP	PAIN	WEIGHT
9/11/11 @ 0412	96.4	85	20	135/81	99	

Gen: NAD
HEENT: PERRLA, EOMi, moist mucous membranes, no LAD, no JVD
Cardiac: distant heart sounds, S1, S2, borderline tachycardic 90s to low 100s, trace BLE edema
Pulm: CTAB
Abdomen: soft, non-tender, non-distended, + BS in all 4
Neuro: 4/5 strength BLE

Labs:
WBC: 5.6, with increased PMNs, H/H: 10.7/32.6, Plt: 72
K: 3.8 Cr: 1.1
U/A: + Protein, + Nitrates, Large leukocytes, TNTC WBC, many bacteria

Radiology:
CT Chest:
1. Filling defects in the subsegmental branches in the right
lower lobe pulmonary artery consistent with pulmonary embolism.
2. Bibasilar atelectasis and mild interstitial edema. Emphysema.
3. 6.5 x 6.4 cm hypodense lesion in the spleen as above.
Differential includes metastatic disease, lymphoma however,
lymphangioma or hemangioma can be considered. Moderate pattern in the rest of the spleen could be due to early phase of contrast however, additional splenic lesions cannot be excluded. Recommend further evaluation with an abdomen CT.
4. 12 mm left adrenal gland nodule.

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A/P: 91 yo M with a history of DM2, BPH, GERD, glaucoma and recent bullous phemphigoid, currently in remission with steroids and cyclophosphamide treatment, presenting with sinus tachycardia, dry cough and dysuria, found to have small PE in the RLL and UTI, initially treated with heparin gtt, c/b by acute drop in H/H, now stabilized after D/Cing heparin and transfusing 1 u PRBCs.

Anemia. Most likely multifactorial, with evidence of underlying anemia of chronic disease on Fe studies, with drop presumably due to GI bleeding, but now stabilized after 1u prbc.
- H/H stable at 9.7 this am

Tachycardia/cough. Treated for PNA upon admission. Now has radiographic evidence of a PE in the RLL on Chest CT. Pt has no complaints c/w DVT, denies leg pain, swelling, redness.
- start heparin gtt and Coumadin
- Pt failed anticoagulation therapy with acute worsening of H/H without a readily identifiable source, and falling Plts in the setting of heparin therapy.
- Will c/s IR for IVC filter placement

Dysuria. UTI with grossly positive UA.
- Check urine culture
- UCx no growth at 24 h (specimen was collected after starting Abx)
- Start on unasyn
- Currently on Unasyn 3gm Q6 for UTI, continue while inpatient
- condom cath in place

Bullous Phemphigoid. Remitting.
- Continue prednisone 100mg QSun, Sat, Tues, Thurs, and 50mg QMWF
- Hold cyclophosphamide 100 daily while platelet count low
- Derm aware that he is here.
- continue symptomatic treatment: hydroxyzine 10 Q6 PRN itching, calamine lotion

thrombocytopenia. Platelets are dropping. Most likely due to cyclophosphamide treatment.
- holding cyclophosphamide for now. Derm on board.
- platelets stable now, trending up slowly after d/c heparin gtt

AMS. Likely delirium secondary to steroid treatment and acute illness.
- continue home meds, risperidone 0.5mg QHS
- Currently not agitated, but will consider haldol 0.5mg IM Q4h PRN for agitation

DM2. continue home insulin regimen
- continue SSI VLD, add HS coverage

GERD. continue home meds: omeprazole 20mg

Glaucoma. continue home meds: Dorzolamide/timolol gtt OU BID, latanoprost 1 gtt OU.

BPH. continue home meds terazosin

FEN. Pt on telemetry for ongoing tachycardia. No need for IVF at this time, as patient is euvolemic. Will check and replete lytes as necessary. Diabetic diet

Ppx.
- no pharmacologic DVT ppx, as pt failed heparin therapy
- SCDs
- senna and colace
- continue alendronate 35 qWeek and ca/vit D for bone protection
- Will re-start ASA when IVC filter placed

#Dispo. Back to SNF after IVC Filter placement

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Progress note #3

Background: This patient is a 75 yo gentleman with oxygen dependent COPD and grade III diastolic dysfunction/CHF very prone to volume overload who presented for SOB. Found to have RLL infiltrate, BNP 2000s (baseline 600s) and significant wheezing on exam. Treated for PNA, COPD exacerbation and CHF at this admission. This note was written by the medical student on HD #3.

Summary statement: Mr. Smith is a 75 year old man with past medical history significant for diastolic CHF, stage III COPD, diabetes mellitus, and CKD who presented with complains of progressive dyspnea most likely due to a COPD exacerbation secondary to a possible pneumonia and possible heart failure.

Subjective:
No acute events overnight. He reports sleeping throughout the night on the recliner chair. His shortness of breath has improved and returned to his baseline. He also notes that his swelling in his feet has decreased. However, he continues to complain of a non-productive cough. He is tolerating PO intake. Patient denies chest pain, chills, abdominal pain, vomiting, diarrhea, or any new acute symptoms.

Objective:
Temp: 96.3 deg C
Pulse: 68 beats/minute
RR: 20 breaths/minute
BP: 192/110
O2Sa: 92% on 1.0 L of O2
Weight: 221.4 lb

General: Atraumatic, normocephalic, not in any acute distress.
HEENT: PEARL, EOMI, mucous membranes moist, hearing intact.
Neck: Supple, no thyromegaly or lymphadenopathy
Pulm: Non-labored breathing. Mild crackles in bilateral bases, no wheezing or rhonchi noted, good air movement, prolonged expiratory phase, no supraclavicular, intercostal, or subcostal retraction, no egophany, tactile fremitus wnl
CV: Distant heart sounds; regular rate and rhythm, no murmurs, rubs, or gallop. Normal S1 and S2. No S3 or S4. elevated JVP (about 7-8cm); no carotid or femoral bruits; 1+ bilateral pitting edema in LE, extends to 2 in above ankles
Abd: Soft, nontender, nondistended. Bowel sounds present. No hepatomegaly or splenomegaly; fluid waves present.
Ext: Dry and scaling skin in the lower extremities b/l, 2+ pulses in extremities, no clubbing or cyanosis
Neuro: Alert and oriented; No focal deficits

Labs:
SODIUM:137 mmol/L
POTASSIUM: 3.8 mmol/L
CHLORIDE: 100 mmol/L
CO2:33.3 H mmol/L
CALCIUM: 8.5 mg/dL
CREATININE-eGFR: 1.1 mg/dL
ANION GAP: 7.5
BUN/CRE RATIO(ID-OUT)(<8/91):29.0
WBC: 14.5 H K/cmm
HGB: 18.5 g/dL
HCT: 56.5 H
MCV: 114.2 H fl
Glucose: 96 mg/dL
BNP: 2290 pg/mL

A/P:
Mr. Smith is a 75 year old man with PMH significant for diastolic CHF and COPD who presents with dyspnea on exertion, lower extremity swelling, subjective fever, non-productive cough, and chest X-ray consistent with fluid and COPD exacerbation secondary to possible pneumonia.

1. Dyspnea: Most likely etiology is COPD exacerbation secondary to a possible pneumonia and volume overload. Symptoms have returned to baseline and patient is breathing comfortably on 1.0 L NC of oxygen. Wheezing noted on previous exam has resolved.

Since patient has been bed bound for several of days, PE continues to be considered. However, patient is currently on sbq heparin making PE unlikely.
- Continue ipratropium and albuterol inhaler
- Begin prednisone taper: Administer 40 mg x 2 days, 20mg x 2 days, 10mg x 2 days, then stop
- Continue moxifloxacin day 3 of 5
- Continue 1L NC of O2

2. Elevated hemoglobin and hematocrit levels: Hemoglobin and hematocrit levels continue to be elevated (Hgb = 18.5, Hct = 56.5). Patient's baseline hemoglobin is 10.5 with a hematocrit of 35.8. Most likely etiology of erythrocytosis is increased epo level in response to hypoxia. Prednisone could also be contributing to the erythropoiesis. To differentiate between primary vs. secondary erythropoiesis, EPO level will be evaluated.
- Follow up on EPO level
- Continue to hold ferrous sulfate

3. Edema: 1+ bilateral LE edema and crackles in the bases of lungs were still noted today. Based on today's weight, he is 9.5 lbs above his “dry” weight. Peripheral and pulmonary edema most likely due to fluid overload secondary to CHF, noncompliance with Lasix, diastolic CHF, stage III CKD, possible pulmonary hypertension secondary to COPD. Patient's home dose of Lasix is 80mg BID, Lasix was restarted at admission
- continue Lasix dose at 80mg IV BID
- Monitor his peripheral and pulmonary edema

4.History of CVD: Since patient is currently stable, we continue his home medication and doses at this time
- Continue 81 mg of aspirin
- Increase metoprolol dose to 100 mg
- Continue 10 mg of simvastatin
- Continue 5 mg PO of Amlodipine
-Continue 10mg lisinopril

5. Hyperglycemia: Most likely secondary to history of type II diabetes mellitus. His glucose levels has decreased to 96 today. Patient received 48 units SSI yesterday.
- Continue 24 units of lantus qhs
- Continue 24 units of aspart tidac
- Continue moderate dose SSI
- Continue to monitor for hypoglycemia as a result of decreasing prednisone dose

6. History of chronic kidney disease: Cr levels were 1.1 and BUN of 29.0, which continue to trend downwards.
- Continue to monitor Cr and BUN
- Continue Lasix to decrease the peripheral and pulmonary edema as noted above

7. Hypocalcemia: Calcium level today is 8.5. Most likely etiology of hypocalcemia on admission is CKD and acid-base disturbance.
- Obtain Vitamin D levels
- Check PTH
- Monitor his ionized Ca levels

8. History of peripheral neuropathy: Most likely secondary to DMII
- Continue gabapentin

Prophylaxis: Subq Heparin and omeprazole

Diet: Cardiac diet

Code: Guarded

Disposition: Patient will be discharged home today if he continues to be medical stable

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Progress Note #4

Background: Pt is a 70 yo gentleman with ESRD s/p transplant several years ago, CAD, CHF who presented for pre-syncope found to be in cardiogenic failure secondary to bradycardia from inadvertent overdose of diltiazem/metoprolol in setting of slow afib. Pt required glucagon drip but never required external pacing. He also had volume overload requiring diuresis and bipap, and AKI which improved with resolution of bradycardia This note was written by the intern on HD #3

S: There were no acute events overnight. No complaints this morning including NO: chest pain, SOB, lightheadedness, dizziness. HR WNL last night.

all other systems reviewed and negative unless otherwise stated

O: 36.9 (37.4) 80-97 14-16 95-98%RA 128-205/53-90 I/O -1.4L

Gen: comfortably lying in bed in NAD
HEENT: NCAT, OP clear, PERRLA w/L exotropia
CV: RRR nl s1s2, no m/r/g
RESP: decreased at BL bases, mild crackles, no wheezes
ABD: soft NTND
EXT: warm, well-perfused, 2+ BLLE pitting edema
NEURO: A+O x3, non-focal

CBC W/DIFF; BLOOD
Coll. Date: 11/02/11 05:00

Test Name	Result	Result	Units	Range
WBC	5.7		K/cmm	4.8 - 11.0
RBC	5.3		M/cmm	4.5 - 6.1
HGB	12.9 L		g/dL	14 - 18
HCT	40.1 L		%	42 - 52
MCV	76.3 L		fl	80 - 100
MCH	24.7 L		pg	27 - 33
MCHC	32.3 L		%	33 - 37
RDW	19.7 H		%	11.5 - 14.5
PLT	176		K/cmm	130 - 400
MPV	9.4		fl	6.0 - 10.4
EO#	0.1		K/cmm	0.0 - 0.7
BA#	0.1		K/cmm	0.0 - 0.2
GR#	3.7		K/cmm	1.4 - 6.5
GR%	65.9		%	42 - 75
MO%	14.8 H		%	1.7 - 9.3
MO#	0.8 H		K/cmm	.11 - .59
LY%	16.1 L		%	21 - 51
LY#	0.9 L		K/cmm	1.2 - 3.4
EO%	2.0		%	0 - 7
BA%	1.2		%	0 - 2

CHEM COMP. METAB PANEL (14); PLASMA
Coll. Date: 11/02/11 05:00

Test Name	Result	Result	Units	Range
GLUCOSE(CX7-OUT	248 H		mg/dL	70 - 110
BUN UREA NITROG	23 H		mg/dL	6 - 20
SODIUM(CX7-OUT)	136		mmol/L	135 - 143
POTASSIUM(CX7-O	4.0		mmol/L	3.6 - 5.0
CHLORIDE(CX7-OU	106		mmol/L	101 - 111
CO2(CX7-OUT)	24.2		mmol/L	21 - 31
CALCIUM(CX7-DEL	9.6		mg/dL	8.4 - 10.2
ANION GAP(CX7-O	9.8			-

OSMOLALITY(CX7-	284.0	mOsm/L	278 - 305
BUN/CREAT RATIO	15.2		-
CREATININE-eGFR	1.5 H	mg/dL	0.5 - 1.2

PT/INR/PTT/AC(>1-27-06); PLASMA
Coll. Date: 11/01/11 08:30

Test Name	Result	Result	Units	Range
PT (>3-20-00)	23.6 H		Sec.	11.7 - 14.6
INR (>3-20-00)	2.2		RATIO	-

11/01/11 TTE
Interpretation Summary The left ventricle is normal in size. There is mild concentric left ventricular hypertrophy. Ejection Fraction = 55-60%. The right ventricle is normal in size and function. There is mild tricuspid regurgitation with calculated right ventricular systolic pressure of 28 mmhg. Borderline aortic root dilatation. No significant change from study performed 2/23/2011.

ASSESSMENT
70yo vet with ESRD s/p transplant, AFib on warfarin, CAD s/p NSTEMI, T2DM, HTN, OSA, falls, GERD, BPH, tracheal stenosis, gout, s/p appy admitted 10/31/11 after episode of pre-syncope at home. Brady in ER.

DDx is
- accidentally overdose of diltiazem and metoprolol for one week (likely)
- ischemic event (unlikely, no chest pain, trops neg, EKG w/o new ischemic changes)

Now improved after drip

PLAN
CV
#)bradycardia
- DDx as above
- HR well controlled past 24hrs and with patient walking around floor
- continue home metoprolol 150mg po BID
- d/c dilt indefinitely
- Holter monitor for home going
- home health aide c/s placed to help patient and wife with proper med accounting

#) paroxysmal AFib/flutter on chronic warfarin . . . stable
- admission EKG demonstrated flutter w/8:1 block
- metoprolol as above, hold dilt
- continue home dose of warfarin 7.5mg MFW, 5 TThSaSu, monitor INRs

#) CHF
- LV function WNL and stable as per TTE above
- volume overload improved s/p IV lasix
- continue home lasix dosing (80/40) upon discharge

#) CAD
- metoprolol, ASA, holding diltiazem, simvastatin

FEN/Renal
#) AKI on CKD
DDx: intravascular volume depletion vs heart failure (i.e. cardiorenal syndrome vs low output) vs intrinsic renal disease from graft rejection vs intrinsic renal disease from medication side effect
- baseline Cr 1.7-2 . . . . 3.7 on admission . . . . now 1.5
- continue lasix as above
- monitor daily lytes, renal fxn
- Medications have dose reduced for decreased gfr 29

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#) s/p renal transplant
- renal consulted
- tacro level 12.8 on admission . . . 6.8 today
- continue tacro 2mg/1mg . . . . monitor level daily, adjust as needed
- continue home MMF dose 500mg po BID

#) NEURO
- Pt with episode of headache/lightheadeness/dizziness/presyncope, resolved
- Diabetic neuropathy in hands, on gabapentin 400mg BID, dose reduced to QD while inpatient due to decreased GFR

#) ENDOCRINE . . . IDDM
- insulin reduced on admission, sugars high overnight . . . will increase glargine to 50U qhs
- continue home aspart 16U TIDAC

#) GI
- Elevated AST, ALT, AP and GGT
- coming down, monitor

#) PULM
- CXR with severe pulmonary vascular congestion, no focal airspace opacities or large pleural effusion
- Off bipap
- Crackles on exam . . . improving
- Saturating well on RA
- CPAP at night

#) GU
- Cont terazosin

#) PROPH
- Home docusate, omeprazole

#) CODE
-No mechanical ventilation or intubation

#) ACCESS
-PIV

Progress Note Checklist

Learner: _____ Patient:_____ Date:_____

	No	Yes
1. Summary statement concise review of patient's history and course	__	__
Comments:		
2. Summary statement appropriately updated	__	__
Comments:		
3. Subjective includes status of symptoms which led to admission	__	__
*"No overnight events" is **not** sufficient*		
Comments:		
4. Subjective is sufficiently detailed	__	__
Comments:		
5. Results of important studies and consultants recommendations since the last Progress Note reviewed and analyzed in Subjective or Assessment	__	__
Comments:		
6. Assessment lists each **active** problem separately in order of importance	__	__
Resolved/stable/inactive problems should not continue to appear		
Comments:		
7. Assessment demonstrates learner's thinking about the problem	__	__
Comments:		
8. Specific plans clear in the assessment	__	__
Comments:		

This checklist is provided to facilitate evaluation and feedback of the learner's daily progress notes. One evaluation per week of each learner is expected. These should be reviewed with the learner. This form is not expected to be part of the learner's grade file and need not be turned in.