

## GUIDELINES FOR PROGRESS NOTES

### Basic rules of documentation:

1. Date and time all notes.
2. Include a brief title for all medical record entries; identify yourself and your role (eg. Intern Progress Note).
3. Avoid abbreviations.
4. Using the electronic medical record (WebCIS) to compose and print notes for signature and inclusion in the chart is encouraged.
5. Rote cutting and pasting from previous notes without editing and updating is not permitted; using another provider's observations or assessments is unethical and unprofessional.
6. If writing in the paper record, use blue or black ink; for errors, draw a line through the erroneous entry and initial.
7. In addition to signing notes, be sure to print your name legibly and include your pager number.

### Progress notes:

1. The purpose of progress notes is to provide a daily account of your patients and their illnesses, and of developments in their diagnosis and treatment, for all of those who share in their care.
2. They should be written in the problem-oriented, SOAP format, as follows:
  - a. "Subjective" should include information from the patient about their symptoms and wishes, and from family and from other caregivers (eg. "nurse reports the patient had a sleepless night.")
  - b. "Objective" should only include new information. Information that is readily available to others can be briefly summarized, or include only abnormal or changing results. This section should include the following kinds of information:
    - i. vital signs and physical examination (ie. results of an appropriate, focused exam)
    - ii. lab data
    - iii. imaging data
  - c. Assessment and plans should be summarized BY PROBLEM. Problems may be diagnosed diseases or syndromes, or symptoms, symptom complexes, or abnormalities from the exam, labs or imaging. Although sometimes a problem may be best expressed by reference to an organ system, eg. "pulmonary abnormalities," generally the problem list is not simply a list of organ systems (some diseases or problems involve several

organ systems; some organ systems may have more than one discrete problem)

- i. the assessment is the MOST important part. It can be brief, but should include the working differential diagnosis or established diagnosis, the severity or the prognosis when appropriate, and the “status” of the problem, i.e. whether the patient is improved, has worsened, or has developed additional problems. It is where one interprets the changes in the patient’s subjective status, the new diagnostic test results, summarizes input from consultants, and articulates an opinion re: the unfolding of the patient’s diagnosis and treatment
    - ii. the plan is what is next; it may be divided between diagnostic (or monitoring) plans and therapeutic plans
  - d. The required “last problem” (analogous to concluding ambulatory problem lists with “health maintenance”) should be “disposition” or “discharge planning” and should always include discharge planning or needs.
  - e. A “Formulation” or “Impression” is not required for every progress note, and should not simply be a recapitulation of the patient’s past or present diagnoses or findings. A brief overall assessment may be provided when it is helpful to have summary assessment of the patient’s status or progress, or his or her cumulative morbidity, or the interaction of various separate problems.
3. Progress notes can and should be relatively brief, focusing on developments since the previous note, and recapitulating only relevant, ongoing, active problems. Cutting and pasting from previous notes without editing or updating is not permitted, and outdated and redundant information should be eliminated from notes.
4. Please see Sample Progress Note on following page.

## SAMPLE PROGRESS NOTE

2-14-05, 11:40 am

### Intern Progress Note

S) Today she feels worse, failed a trial of p.o. nutrition and has been vomiting most of the night.

O) exam: appears comfortable.  
VS: P 110 110/70 T 98.2 RR16  
mucosa are dry  
abdomen is soft but mild mid-epigastric tenderness to  
palpation and bowel sounds are absent.  
labs: amylase increased from 150 to 600  
Na 148 Cr 1.8

A/P)

1. Idiopathic pancreatitis, failed a trial of oral feeds yesterday, her 5<sup>th</sup> hospital day, persistent ileus by exam, clinically dehydrated  
Plan: increase IV fluid repletion, npo  
consider paraenteral nutrition – call GI  
repeat CT of her abdomen once renal function improves
2. Incr'd Na, creat, c/w dehydration, volume depletion
3. Discharge planning. Prolonged illness will likely require sub-acute rehab before return home.