Writing Progress Notes (.IMPROG)

Progress notes serve two vital functions in patient care:

•**Cognitive**, the process of writing progress notes is your time to **re-think your assessments and plans and make sure they make sense and are complete** (e.g. that your diagnoses are correct, the patient is responding to therapy, you're not missing something important, and that you're preparing them for discharge).

•**Communication,** they are the **primary** way in which your team **reports** what is happening acutely to your patient, what your team thinks about it, and what your team's plan is**.** Consultants look at these notes in order to understand what's going on with your patients. If your patient gets sick while you're not here, cross-covering residents will look to your notes to help them understand what's changed and what they should do.

Progress notes are crucial in providing good patient care.

Consequently, it is essential that your notes be accurate, focused and current. They must reflect the current status of your patient and what your team is thinking at the time you wrote your note. They should reflect the important data and events of that day.

Two "short-cuts" must be avoided: 1) the 8am note (e.g. before labs are back, before you've done walk rounds with your resident); **2) the copy-paste note** (**and its variants**, including the "30 pages of labs and old x-rays" note, the "Admission H&P + daily edits" note, the note with 400-word radiology reports). They destroy the value of your note.

WARNING: You will be tempted to generate your notes via "copy-paste". RESIST that urge! Copy-paste is simply a fast way to do something useless! A copy-pasted note is the worst possible note – it shows contempt for the functions of progress notes –and reflects poorly on the writer, the team, and the hospital.

• Use .**IMPROG** for the Elmhurst Medicine Progress Note template

• **Subjective** section includes any symptoms that patient may spontaneously volunteer **as well as pertinent positives and negatives** for whatever their active diagnosis is (e.g. for a patientt with pancreatitis, "No abdominal pain or vomiting, interested in trying PO today"). Significant events since yesterday's note are also reported here.

• **Exam** (Indicate whether O2 sat is "RA" or e.g. "2 lit NC").
include pertinent positives and negatives for your pt's (differential) diagnoses. *Don't copy-paste from day prior!*

• **Labs and Diagnostic Tests and Meds**

- **.IMPROG** pulls the med list. **Look at the meds listed!** (is something missing? Does anything need dose adjustment?)
- **.IMPROG** pulls the common labs (via **.LABTRENDS**). Type in any other **important** labs, or *alternatively, don't use a dot phrase, and just type in the labs you think are notable (e.g. pertinently positive or negative)*. If your pt has cultures pending, type these here. (e.g. "Bld-cx 9/24: NGTD")
- **Don't forget to actually look at the lab results and think carefully about what they mean**!
- **Consider which labs you need for the next day.** (*Resist the temptation to order routine daily labs!***)**
- **BCxs, Imaging, EKG section.** Type these in if anything new.
- **Never copy large blocks of text from an imaging study.** Just type the relevant result (e.g. "no infiltrate", or "3.5cm spiculated mass RUL"). (dotphrase ".WETREAD" *may* be terse & useful; *if not, just delete it*!)

• **Assessment/Plan This is the most important section of your note**, where you lay out the problems you have identified and what you're doing about them. Start with a one-line assessment (e.g. "69M with history of severe COPD and HFrEF, here for COPD Exacerbation/Pneumonia, is improving.") Follow this with a **problem-based plan which lists each of the patient's active problems and what you're doing about them.**

- **Do NOT simply copy/paste the assessment/plan from the day prior!**
- **Problem-based.** Generally, the standing meds should be explained by/listed in this plan (e.g. HTN –well-controlled, cont lopressor 50, Telmisartan 40; DM2 – AM FS 230, increase Lantus from 20 to 25, continue Lispro 6 AC meals). **Do NOT simply write "continue current meds"**
- **Dispo/Barriers** Why does the patient still need to be in the hospital? What has to happen before the patient can be discharged? Where are they going? Get the ball rolling early!
- **Outpt F/U Needs** Keep track here of things that need to be followed-up as outpatientt, including abnormal labs/imaging, repeat imaging, in-progress labs, clinics (use this at discharge!)

If anything important happens after you write your note, write a separate **Significant Event Note** (short and sweet: what happened, what are you going to do about it)