**MS3/MS4 Note Writing and Presentation Guidance for History & Physicals and Daily Progress Notes**

Overarching goals: Your note and presentation should be **ACCURATE, INFORMATIVE,** and **CONCISE**

Main points:

* Many notes are copy-forwarded, thus you must be very cautious to review the note **thoroughly** to prevent outdated info from populating forward.
* Avoid **note-bloat** by removing data older than 24 hours and cutting RESOLVED problems from daily progress note and pasting them into the hospital course.
* Learn **common abbreviations** as quickly as you can, they are your friend! They improve note bloat and efficiency greatly. *Please note common abbreviations throughout this guidance.*

**SUBJECTIVE for History & Physical (H&P)**

*Chief Complaint* *(CC):* one-line about why patient presented to hospital. Preferably in patient’s own words in quotation marks.

*History of Present Illness (HPI):* Start with “[Name] is a [age]yo [sex] with a Past Medical History (PMHx) of [diseases] who presents with [symptoms/complaints]. Then continue with all the details from your interview.

*ED Course:* briefly state what happened in the ED. Significant lab or imaging findings. Were fluids or antibiotics (ABX) given, etc.

*Review of Systems (ROS):*

*Past Medical History (PMHx):*

*Past Surgical History (PSHx):*

*Medications (Meds):*

*Allergies: no known drug allergies (NKDA)*

*Social History (Social Hx or SHx):*

*Family History (Fam Hx or FHx):*

**SUBJECTIVE for Daily Progress Note (DPN)**

*One liner:* brief sentence stating patient's age, sex, and why they are in the hospital. No need to say their long list of past medical history (PMHx), UNLESS it is directly pertinent to the reason for admission.

*24 Hour Events*: report pertinent medical events from the past 24 hours. Examples: received 2 units of blood for hemoglobin (Hgb) of 5.2, successfully extubated at 6PM, rapid response called at 2AM for…, goals of care discussion with family where patient was made Do Not Resuscitate (DNR), etc.

*Subjective:* brief info on how patient is doing. You and the patient may have talked 30 minutes about their pets or job, but only share what’s medically pertinent here. Are they reporting pain, difficulty breathing, a reaction to a medicine, the desire to leave against medical advice (AMA), depressed mood and wanting to see Psych or a chaplain, etc.

\*Do not chart or present objective data in the Subjective section, unless it seems appropriate to place in the *24 Hour Events* section.

**OBJECTIVE for H&P and DPN**

*Vitals (V/S):* Ranges will auto-populate with both H&P and DPN templates. Reporting the vital RANGES is most important, not the last charted vitals. When you are a brand-new beginner, verbalize all ranges of vitals on presentation. As you get more experienced, you can just verbalize what’s remarkable.

*In’s and Out’s (I/O):* can **create a dot phrase** for *24 hour I&Os*. [Manage AutoText -> create new -> select Insert Templates/Tokens -> search “I&O” and select]. Can view/chart Net I&O since beginning of admission from the IPASS on your Rounds List.

*Physical Exam (PE)*: once again, learn the common abbreviations, they are your friend! Similar to vitals, present full exam as a beginner, then you can move more towards just presenting remarkable findings as you are more experienced. Update this daily, do not document physical exam findings from prior days if you didn’t do that exam today.

Example:

GEN: well developed adult in no acute distress (NAD)

HEENT: normocephalic/atraumatic (NC/AT), extraocular movements intact (EOMI), pupils equal round and reactive to light and accommodation (PERRLA), benign oral-pharynx (OP), no lymphadenopathy (LAD)

CV: regular rate and rhythm (RRR), no murmurs, rubs, or gallops (no m/r/g), normal jugular venous pulse (JVP)

RESP: normal work of breathing, clear to auscultation bilaterally (CTAB), no wheezes, rales, or rhonchi (w/r/r)

ABD: soft, non-tender/non-distended (NT/ND), normoactive bowel sounds (NABS), no masses palpated

EXT: warm and well perfused, no peripheral edema, strong symmetrical radial pulses

NEURO: awake, alert, and oriented x 4 (AAOx4), moving all limbs spontaneously, CNII-XII grossly intact

PSYCH: congruent mood and affect

*Labs:* can use dot phrases (.labs\*) or free text what is pertinent. Only verbalize what is pertinent (abnormal values and values that are normal that you’ve been trending).

*Micro:* always DATE your micro labs, particularly all cultures. Remove results older than 24hours old for the daily note, EXCEPT cultures (blood, urine, sputum) until Final Report is resulted. Can **create a** **dot phrase** for all cultures that will include date and ID numbers: [Manage AutoText -> create new -> select Insert Templates/Tokens -> search “Culture Results – Last 90 Days” and select].

*Diagnostics:* paste/tag in “Impressions” and/or most pertinent parts of report. Remove reports over 24 hours old.

**ASSESSMENT**

An *Assessment* statement is very important, particularly during H&Ps and when there are big changes or breakthrough with a patient’s care. An Assessment statement is NOT a repeat of your One-Liner, NOT a repeat of the first sentence of your HPI, and NOT supposed to be the same every day (unless nothing is truly changing with the patient). The Assessment statement is YOUR understanding of what is going on with the patient, given all the information you just documented/reported in the Subjective and Objective sections. A statement of who the patient is, what new information has come to light, and why they are being treated in the hospital. The Assessment statement changes every day as you gather more information and further narrow your diagnosis and treatment. It tells your listeners that you have interpreted the information from the Subjective and Objective section and have come up with a direction, diagnosis, therapy, etc. Here is an example of a changing Assessment statement as a patient progresses through their stay:

Day 0 - Mr. Baird is a 72yo M with HTN and COPD who presented with shortness of breath (SOB) with dyspnea on exertion (DOE), requiring use of his inhalers every day, found to be hypoxic on room air (RA) and admitted for concern of a COPD exacerbation.

Day 1 – Mr. Baird is a 72yo M with HTN and COPD who presented with SOB and DOE, admitted for management of acute hypoxic respiratory failure (AHRF) secondary to (2/2) COPD exacerbation.

\*\*Pt not getting better, so a CT Chest is obtained that reveals multiple pulmonary emboli (PE) and a focal consolidation.

Day 2 – Mr. Baird is a 72yo M with HTN and COPD who presented with SOB and DOE, admitted for management of AHRF 2/2 COPD exacerbation, multiple PE’s, and CAP (community acquired pneumonia).

And so on…

**PLAN**

The *Plan* is your list of Active and Chronic problems for the patient, your thoughts/diagnostic workup supporting that problem, and what are the Actions going to be taken for that problem. Actions include medications prescribed, imaging ordered, consults requested, labs ordered, etc. Actions can be listed by dashes or bullet points. At the beginning your problems may be symptoms and diagnoses, such as for Mr. Baird – Hypoxia, Shortness of breath, COPD exacerbation, PE’s, CAP (6 problems). But as you advance in your training and in the workup of your patients, you’ll learn to group problems as you determine their true diagnosis and relation to each other, such as – AHRF 2/2 COPD exacerbation, multiple PE’s and CAP (1 problem). For the ICU, the Plan is SYSTEMS based (Neuro, Respiratory, GI, etc…).

*Bundle:* end your note/presentation with a bundle every day.

-Diet:

-Bowel regimen:

-DVT PPx (deep venous thrombosis prophylaxis):

-CODE status: FULL or DNR (do not resuscitate)

-POC (point of contact):

-Dispo (disposition): this is a statement of why the patient is still in the hospital and where they are going when they leave