

Note Writing Policy

Approved by RACC January 25, 1999

Overview

In order to reconcile the need for adequate documentation of inpatient admissions with the legitimate concerns of housestaff to avoid unnecessary duplication of work, we propose the following policy for housestaff notewriting. The policy is based on three priorities of documentation: communication, medical-legal obligations, and education.

Communication

Admission notes serve a vital communication role, providing consultants, cross-covering physicians, and nursing and other health care staff with information essential to the care of the patient. In addition, the medical record as a whole remains an important source of information for providers reviewing records in future encounters. The functions mandate certain requirements for admission notes:

Timeliness: All admission notes must be completed and in the chart by 8AM on the post-call day.

Accuracy: It is imperative that the note adequately reflects the current plan for care.

Clarity: The note must be legible, complete and concise.

Medical Legal Obligations

Note writing serve an important medical legal function, providing documentation of objective findings and rationale for treatment plans. In order to insure appropriate documentation from a medical-legal standpoint, the UCSF attorneys suggest a few points relevant to note writing:

Chain of supervision: It is important to document the appropriate use of the chain of supervision; if a case has been discussed with the resident or attending, it is appropriate to note that discussion.

Documenting Inconsistencies: It is crucial to document the rationale for any departures from the written plan (ie. if the physician wrote that a study was planned, and then new information was obtained which obviated the need for that study, the physician should document the reason for not proceeding with the study).

It is important for physicians to be educated about the medical-legal issues in medical record keeping; having more senior housestaff and attendings read notes provides an opportunity for feedback and improvement on behalf of interns and students to improve their skills.

Education

Note writing serves an important pedagogic purpose. Well-written notes collect and present data as a coherent story and synthesize an appropriate impression and therapeutic plan. Supervising residents and attendings can play an important role in assisting interns in developing the ability to write such notes.

Residents and attendings should incorporate feedback on note writing for member of their team into their pedagogical activities, so that students and interns have the opportunity to continue to refine this important skill.

Policy:

- 1. All admitted patients must have an admission note written by the intern (or MSIV) responsible for his or her care.**
- 2. Interns (or MSIVs) are responsible to complete notes on ALL patients they admit by 8AM on the post call day. In the case of early AM admissions, the interns should make every effort to get a note in the chart as soon as possible.**
- 3. Residents are expected to read intern notes and add a brief addendum, noting any discrepancies in history, physical, assessment and plan from what the intern wrote and documenting his or her agreement. The resident note should briefly (in one or two paragraphs) state the clinical issues, important clinical findings, and – most importantly – a brief statement and commentary on the central issues, including the clinical plan.**
- 4. All patients admitted by a MSIV “subI” must have a complete note written by the MSIV as well as a brief note (focusing on the major findings on history and physical and the assessment and plan) written by the resident in the chart by 8AM.**
- 5. MSIII admission notes are to serve as additional information, and should be cosigned by a member of the housestaff with appropriate corrections/addendums before being placed in the chart. These may not serve as the primary admission note.**
- 6. Daily progress notes written by medical students (MSIII/MSIV) must be accompanied by a brief addendum and cosigned by a member of the housestaff (intern or resident) or attending before the end of the working day on which they are written. These will serve as progress notes for the patient.**
- 7. Intern progress notes do not need to be cosigned.**
- 8. Residents supervising admissions to critical care units are expected to write an assessment and plan on each patient (in addition to the complete intern note).**