**Electronic Medical Record Documentation**

An essential component of your daily workflow during your internal medicine residency training is electronic medical record documentation. The core competencies associated with medical documentation are as follows:

***Interpersonal and Communication Skills***

***-***Timely and comprehensive documentation and communication

-Provide legible, accurate, complete, and timely documentation

***Professionalism***

-Document and report clinical information truthfully

-Ensure prompt completion of clinical and curricular tasks

***Systems-Based Practice***

-Understand coding principles

**General considerations**

-Documentation should be completed on the **date of service**

-Cutting and pasting portions of **other health care providers’ notes** is unprofessional and unethical

-Copying and pasting from your previously created notes is acceptable **if and only if**:

-it is your original work

-it is edited thoroughly to reflect the **current** clinical status

-**unnecessary and/or outdated clinical information is deleted**

**Documentation Guidelines-Inpatient Medicine**

**EMR system: CPRS**

**Prior to formulating a note, you should initiate an encounter. How to do this will be explained in your orientation.**

**History and Physical Exam**

EMR Title: **Medicine Inpatient Admission Note**

Components:

1. Clinical Pathways: We currently have two pathways, one for heart failure and another for pneumonia. Please do not forget to activate these pathways if your patients are admitted for either one of these diagnoses. You can only use one of these pathways. Example: If your patient is admitted for chf exacerbation due to pneumonia, you would select pneumonia for the clinical pathway.
2. Chief Complaint: Traditionally this is documented as the patient’s

complaint in their own words with a given duration. Ex: “I have been having chest pain for the past five days”.

1. History of Physical Illness: An accurate history is necessary to

understanding the patient’s illness. This should include elements such as onset, duration, quality, severity, timing, as well as pertinent positive and negative symptoms.

1. Review of Systems: A checkbox is already incorporated in our admission note. Eight categories are in this note.
2. Past Medical History
3. Social History
4. Past Surgical History
5. Family History
6. Vaccination History: Recent Immunizations are included in the CPRS face-sheet. Specifically inquire about pneumonia and flu vaccination.
7. Physical Exam

-Vitals on admission

-Please delete vitals that populate on your note that are more than 48 hours.

-Documentation of a comprehensive medical exam. Be honest with your exam. If you did not examine a system, do not include it in your documentation. The EMR template is already organized into organ systems. Please use free text to fully describe the abnormalities.

- Document the presence of all IV lines and include the date and type of line placed; Document presence of NG tubes, PEG tubes as well as presence of a trach

-Document the presence of a Foley, suprapubic, or condom catheter in the GU exam

**Do not pull in lab data, radiology reports, pathology reports, etc in**

**the admission note that is not pertinent to this admission**. If you review outside records from another facility or from VISTA WEB, you may document that such records were reviewed. You may comment on the pertinent findings in your impression.

11. **Spiritual Screening, Admission Alcohol Abuse Screen, Tobacco use Screening**: This needs to be done on admission and documented in CPRS. A template checkbox is already created for this purpose.

1. Outpatient Medications: This should include both the VA medications as well as NON-VA medications. Medication reconciliation should be done on admission to assess compliance with the listed medications as well as potentially uncover any misuse of medications. **We currently have software in place for medication reconciliation. Utility of this tool will be explained in the orientation.**
2. Review of allergies
3. Impression and Plan:

-Need to be as specific as possible: If a patient is admitted with pneumonia: Right lower lobe community acquired pneumonia, organism unspecified at this time

-In addition to the addressed medical problems, include these additional elements: DVT prophylaxis (Type: Mechanical vs. Pharmacological),Code status, Fluid/Electrolytes/Nutrition, and Disposition.

**Medicine Progress Notes**

Note title: Medicine Progress Note

Note Format:

1. Clinical Pathways
2. **Pertinent events** that took place in the past 24 hours: examples include a code blue/gray/white, falls, need for restraints for a specified reason
3. Subjective: This section highlights the patient’s description of his or her symptoms.
4. Objective: Should start with the last 24 hour vitals and then a 5-7 organ system exam. Delete vitals that are greater than 24 hours. Please note that ESSENTRIS VITALS DO NOT POPULATE IN CPRS. You will need to manually type the ranges for each of the vitals. The EMR template is already organized into organ systems. Use free text to fully describe the abnormalities. **This exam should specifically comment on any changes in the physical exam in comparison to the previous day or admission physical exam**.

Remember to document the presence of all IV lines and include the date and type of line placed as well as the presence of a Foley, suprapubic or condom catheter in the GU exam; Also document NG tube, PEG tubes, presence of a trach

- Do not pull in lab data, radiology reports, pathology

reports, etc in your progress notes. Simply document that lab data as well as radiology reports were reviewed, if in fact they were.

1. Active Inpatient Medications
2. Impression and Plan:

**Make sure that your impression and plan is updated and demonstrates progress.** There should be demonstration of a thought process in this part of the note. Further, do not continue to document information from imaging studies, path reports, micro results in subsequent progress notes.

-Be specific with your main active issues and make sure to comment on the clinical improvement of the condition

-Examples: 1. Acute systolic heart failure exacerbation due to medication noncompliance: clinically improved, back to functional status, worsened or relapsed

-**Also make sure to prioritize the main active problems in the assessment that are currently keeping the patient in the hospital**

**Example: If a patient is admitted with congestive heart failure and this condition improves but the patient develops an acute gouty flare or acute kidney injury that is now keeping the patient in the hospital, make sure to place these as the first diagnoses. Further, when you are placing an encounter, make sure that the main diagnosis keeping the patient in the hospital is the primary diagnosis in the encounter. In the above example, it would be either acute gouty flare or acute kidney injury.**

-In addition to the addressed medical problems, include these additional elements: DVT prophylaxis (Type: Mechanical vs. Pharmacological),Code status, Fluid/Electrolytes/Nutrition, and Disposition.

Your impression and plan should be reflective of the decision making made during your rounds with your attending physician.

Again, be careful with copying and pasting. It is ok to copy and paste from your previous notes with modification to reflect the current clinical scenario. Example: If your first note states that an MRI is pending, do not continue to paste this into your progress notes once it was done. **REMEMBER, YOUR PROGRESS NOTE REPRESENTS THE WHOLE TEAM, WHICH INCLUDES YOUR ATTENDING.**

**Discharge Note**

Please ensure that we use the medication reconciliation tool. We will elaborate more on this later in the orientation.

We can only list one principal diagnosis. Please put the diagnosis that was initially responsible for the patient’s admission.

For secondary diagnoses, we can list as many that were addressed during the inpatient stay.

Example: If the patient was admitted for congestive heart failure but developed acute kidney injury and/or acute gout during the hospital stay, you would place congestive heart failure as the principal diagnosis and acute kidney injury and/or gout as the secondary diagnosis.

Make sure to add the patient’s PCP as an additional cosigner to the discharge summary and note.

You do not need to place a medicine progress note in addition to the discharge note, **if and only if you do the discharge summary that same day which will have to include a section demonstrating a soap note format.**