NEW YORK-PRESBYTERIAN HOSPITAL
COLUMBIA UNIVERSITY MEDICAL CENTER
INTERNAL MEDICINE RESIDENCY PROGRAM

POLICY AND GUIDELINES FOR DAILY PROGRESS NOTES FOR WARD PATIENTS

On General Medicine, Cardiology, and Oncology ward services, interns are required to write one progress note during their 24+3-hour on-call duty period. This note usually should be written towards the end of the duty period, in the morning of the post-call day, and should summarize events over time.

This applies to ward and private patients. All patients must still be seen (interviewed and examined as appropriate) daily by their intern.

Suggested guidelines for notes are attached.

EXCEPTIONS:

Exceptions will be for patients in step-down units and ventilated patients. Daily exams and written notes on these patients will continue to be required.

As always, event notes should be written on any patient whose status has changed overnight (ie. over the night prior to the call day) or who changes through the course of the on-call duty period.

WEEKENDS:

On the weekends, the long call intern is also cross covering another intern’s list. Note-writing responsibilities on these patients will continue. To accomplish this, on the long-call morning, the intern and the resident should split exam and note-writing responsibilities on the cross coverage list. The notes do not need to be written prior to rounds, but all ward patients should be seen by either the intern or the resident before attending rounds in the AM. On the post call morning, the intern should, as described above, write end of shift notes on all their own patients. They should again split exam and note-writing responsibilities on the cross cover list with their resident. The intern cannot write more than 16 notes.

GUIDELINES FOR INTERN 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; those on the hospital’s Do Not Abbreviate list are prohibited.
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 is strongly discouraged; 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 (e.g. “nurse reports the patient had a sleepless night.”)
   b. “Objective” should only include new information. As this information is readily available to others, it 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, e.g. “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 “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.

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 is discouraged and outdated and redundant information should be eliminated from notes.

SAMPLE PROGRESS NOTE

2-14-05, 11:40 am
Intern Progress Note

S) Today she feels worse, failed a trial of oral 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 there is 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 5th 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. Increased Na, creat, c/w dehydration, volume depletion

3. Discharge planning. Prolonged illness will likely require sub-acute rehab before return home.

*Updated 2/22/05*