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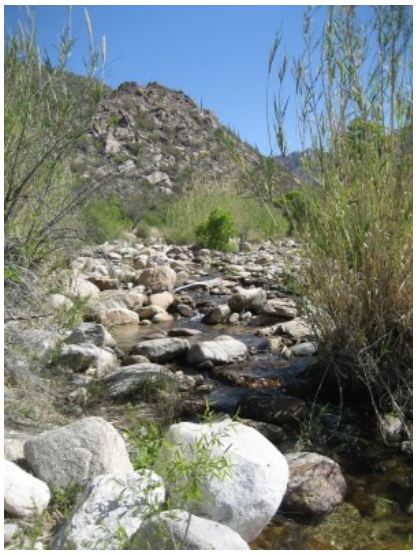
Hospitalist Update



The Daily Progress Note

Emily Coberly MD

During my intern year, I usually arrived at the hospital early each morning to pre-round. After putting on my white coat, I would head to the nursing station where I would grab a stack of yellow progress notes. Before seeing each patient, I would review all of the morning labs and copy them into the empty fish bones that were stamped onto the bottom half of the progress note page. The next stop was the medication room, where I copied each patient's daily medication list from the red binder to my paper. I then traveled to each patient's room where I transcribed the vital signs from the bedside chart onto the progress note, being careful to leave room at the top of the note so that I could enter the subjective data later. After morning rounds, I wrote in the assessment/plan section and returned to the nursing station, where I removed a patient label from each chart, fixed them to the top of the appropriate page and inserted the note into the chart folder. Of course, a certain percentage of charts were always missing from the rack, either gone with the patient for a procedure or grabbed by a consultant team for their rounds.

Since our hospital implemented an electronic medical record and converted to electronic documentation, the process of writing a daily progress note has changed dramatically. It is now possible to obtain vital signs, lab data and medication lists for a patient from anywhere in the hospital with a click of the mouse. Progress notes are typed and can be immediately forwarded to other members of the health care team, including primary care doctors and consultants.

There are several clear advantages to electronic documentation. Electronic notes are more accessible and better organized than handwritten notes [1]. They eliminate legibility problems and are more readily available to other members of the care team; the data in these records can also be more easily obtained for billing and research purposes. Considering these advantages, electronic documentation can improve communication, efficiency and note accuracy.

Unfortunately, electronic notes also create a new set of challenges. Compared with paper notes, electronic records are longer and more redundant [1]. They can also take more time to write [2], though this fact does not consider time saved in the (continued)

(cont) manual collection of data. To increase efficiency in writing their electronic records, many physicians take advantage of features such as "copy forward" or "copy and paste." While these tools can be helpful, the failure to review and update the notes leads to the inclusion of inaccurate, outdated and extraneous information which can make the note unreliable and/or difficult to interpret [3]. This is a common problem in hospitals that use electronic documentation with up to 20% of clinical notes demonstrating use of the copy and paste option [4]. As a result, electronic notes are often long, overly detailed and redundant (compared with written notes, which were often short, illegible and difficult to locate). Despite these new problems, most physicians feel that the benefits of electronic records justify their use and would not recommend a return to handwritten, paper documentation [4].

It is easy to focus on the problems of new technologies and lose sight of the purpose of our notes. Physician documentation is important for research, billing and legal purposes but is especially vital for effective communication with other members of the healthcare team. As we look for ways to improve the quality and efficiency of progress notes, we will need to consider the development of templates and invest more time in learning how to fully utilize the system that we have; making an effort to teach residents and medical students how to construct quality notes will be equally important. While working to overcome the new challenges produced by electronic documentation, we must stay focused on the essential purpose of our daily notes.

1. Embi, PJ et al., *Impacts of computerized physician documentation in a teaching hospital: perceptions of faculty and resident physicians*. J Am Med Inform Assoc, 2004; 11 (4): 300-309

2. Poissant, L et al., *The impact of electronic health records on time efficiency of physicians and nurses: a systemic review*. J Am Med Inform Assoc, 2005; 12(5): 505-516

3. Hirschtick, RE, *A piece of my mind: Copy and paste.* JAMA, 2006; 295(20): 2335-2336

4. Yackel, TR and PJ Embi, Copy-and-paste-and-paste. JAMA, 2006; 296 (19): 2315

HOSPITALIST CONFERENCE & LUNCHEON

MISSOURI ACP MEETING

<u>THIS SATURDAY</u>, SEPTEMBER 26, 12:15 PM

TAN-TAR-A RESORT, LAKE OF THE OZARKS

TOPIC: HOSPITAL ACQUIRED INFECTIONS

http://www.acponline.org/meetings/chapter/mo-2009.pdf