Purpose of Progress Notes

• Facilitate care of patients
  – Permanent record
  – Consultants
  – Hand offs
• Medical legal document
• Billing
• Education of writer
Progress Notes - Issues

• How long?
• Meds?
• Lab?
• X-Rays?
• When to be written?
Progress Note

• Summary statement
Progress Notes

• **Summary statement**
  – Can be cut and pasted forward
  – Significant updates and corrections
Progress Note

• Subjective
  – Update of admission symptoms
  – New symptoms or problem

• Objective
  – Updated & directed physical exam
Impression and Plan

• Don’t repeat the summary statement
• Problem based
• List each problem separately
• Most important problem should be first
Impression and Plan

• Each problem should include some discussion
  – Include synthesis of lab data and test results
  – Consultant’s recommendations
  – Include your THINKING – WHY
Impression and Plan

• Should be NEW and UPDATED every day
• Most important part of the note
• Not necessary to include all stable problems
• Disposition and prophylaxis always good to include to keep you on track
Impression and Plan

• Identify your plans
• Be specific
• Avoid “to consider”
• Use if/then statements instead
• Each problem should have a separate plan
Impression and Plan

- Use your plan to communicate what you need to know
- What questions do you need your consultants to answer?
- What are you troubled by?
- Should be a working document!
Summary

• A good progress note is:
  – Focused
  – Targeted
  – Well organized
  – Specific
  – Updated daily
  – Has a plan
  – User friendly!