Beyond the H&P: Writing Clinical Notes as a Junior Medical Student

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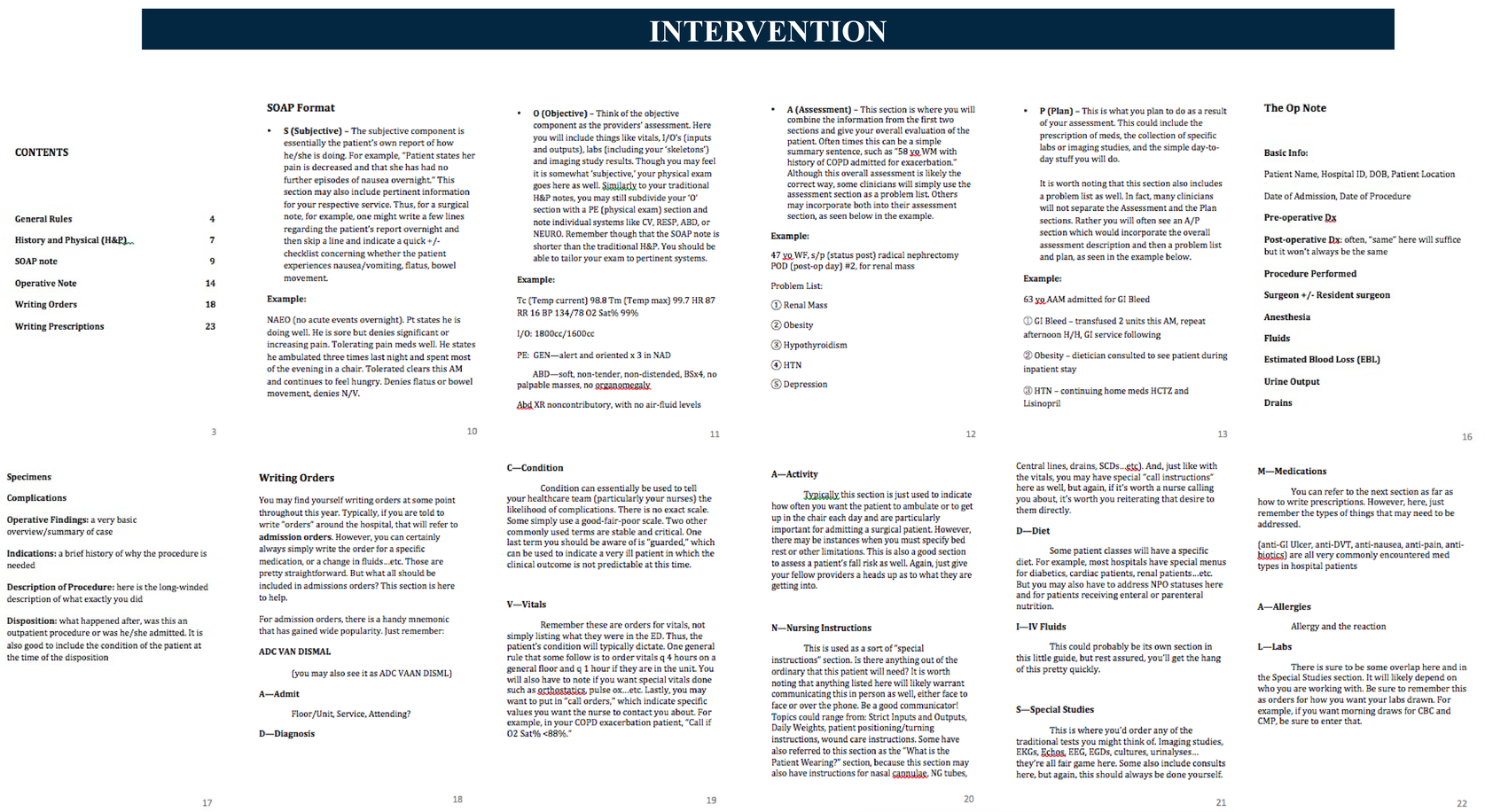
INTRODUCTION

The assessment and evaluation of written communication is included within the sex competencies established by the Accreditation Council for Graduate Medical Education.[1] Additionally, these skills are widely represented in American medical curricula.[1] Still, few studies have identified the types of written documentation that are evaluated or how these are assessed.[2] There is relatively little published literature regarding the challenges that writing patient care notes as a junior medical student present. However, numerous posts and inquiries on web-based resources for medical students indicate that many students struggle with patient care notes as they begin their clerkships. Additionally, the large volume of resources made available on the websites of individual medical institutions may support the notion that these challenges persist year after year for some time now.

After a thorough review of the clinical medicine curriculum during the first and second year of medical education at the author's institution, training was found to put considerable emphasis on the History and Physical (H&P) type of note writing. Various other types of patient care notes, such as progress notes or "SOAP" notes, admission notes or operative reports, were underrepresented in the curriculum by comparison. A review of web-based forums for medical students indicated that other institutions may have similarly focused training.

INTERVENTION



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Specimens

Complications

Operative Findings: a very basic overview/summary of case

Indications: a brief history of why the procedure is needed

Description of Procedure: here is the long-winded description of what exactly you did

Disposition: what happened after, was this an outpatient procedure or was he/she admitted. It is also good to include the condition of the patient at the time of the disposition

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SOAP Format

- **S (Subjective) –** The subjective component is essentially the patient's own report of how he/she is doing. For example, "Patient states her pain is decreased and that she has had no further episodes of nausea overnight." This section may also include pertinent information for your respective service. Thus, for a surgical note, for example, one might write a few lines regarding the patient's report overnight and then skip a line and indicate a quick +/- checklist concerning whether the patient experiences nausea/vomiting, flatus, bowel movement.

Example:

NAEO (no acute events overnight). Pt states he is doing well. He is sore but denies significant or increasing pain. Tolerating pain meds well. He states he ambulated three times last night and spent most of the evening in a chair. Tolerated clears this AM and continues to feel hungry. Denies flatus or bowel movement, denies N/V.

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Writing Orders

You may find yourself writing orders at some point throughout this year. Typically, if you are told to write "orders" around the hospital, that will refer to **admission orders**. However, you can certainly always simply write the order for a specific medication, or a change in fluids…etc. Those are pretty straightforward. But what all should be included in admissions orders? This section is here to help.

For admission orders, there is a handy mnemonic that has gained wide popularity. Just remember:

ADC VAN DISMAL

(you may also see it as ADC VAAN DISML)

A—Admit

Floor/Unit, Service, Attending?

D—Diagnosis

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- **O (Objective) –** Think of the objective component as the providers' assessment. Here you will include things like vitals, I/O's (inputs and outputs), labs (including your 'skeletons') and imaging study results. Though you may feel it is somewhat 'subjective,' your physical exam goes here as well. Similarly to your traditional H&P notes, you may still subdivide your 'O' section with a PE (physical exam) section and note individual systems like CV, RESP, ABD, or NEURO. Remember though that the SOAP note is shorter than the traditional H&P. You should be able to tailor your exam to pertinent systems.

Example:

Tc (Temp current) 98.8 Tm (Temp max) 99.7 HR 87 RR 16 BP 134/78 O2 Sat% 99%

I/O: 1800cc/1600cc

PE: GEN—alert and oriented x 3 in NAD

ABD—soft, non-tender, non-distended, BSx4, no palpable masses, no organomegaly

Abd XR noncontributory, with no air-fluid levels

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C—Condition

Condition can essentially be used to tell your healthcare team (particularly your nurses) the likelihood of complications. There is no exact scale. Some simply use a good-fair-poor scale. Two other commonly used terms are stable and critical. One last term you should be aware of is "guarded," which can be used to indicate a very ill patient in which the clinical outcome is not predictable at this time.

V—Vitals

Remember these are orders for vitals, not simply listing what they were in the ED. Thus, the patient's condition will typically dictate. One general rule that some follow is to order vitals q 4 hours on a general floor and q 1 hour if they are in the unit. You will also have to note if you want special vitals done such as orthostatics, pulse ox…etc. Lastly, you may want to put in "call orders," which indicate specific values you want the nurse to contact you about. For example, in your COPD exacerbation patient, "Call if O2 Sat% <88%."

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- **A (Assessment) –** This section is where you will combine the information from the first two sections and give your overall evaluation of the patient. Often times this can be a simple summary sentence, such as "58 yo WM with history of COPD admitted for exacerbation." Although this overall assessment is likely the correct way, some clinicians will simply use the assessment section as a problem list. Others may incorporate both into their assessment section, as seen below in the example.

Example:

47 yo WF, s/p (status post) radical nephrectomy POD (post-op day) #2, for renal mass

Problem List:

① Renal Mass

② Obesity

③ Hypothyroidism

④ HTN

⑤ Depression

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A—Activity

Typically this section is just used to indicate how often you want the patient to ambulate or to get up in the chair each day and are particularly important for admitting a surgical patient. However, there may be instances when you must specify bed rest or other limitations. This is also a good section to assess a patient's fall risk as well. Again, just give your fellow providers a heads up as to what they are getting into.

N—Nursing Instructions

This is used as a sort of "special instructions" section. Is there anything out of the ordinary that this patient will need? It is worth noting that anything listed here will likely warrant communicating this in person as well, either face to face or over the phone. Be a good communicator! Topics could range from: Strict Inputs and Outputs, Daily Weights, patient positioning/turning instructions, wound care instructions. Some have also referred to this section as the "What is the Patient Wearing?" section, because this section may also have instructions for nasal cannulae, NG tubes,

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- **P (Plan) –** This is what you plan to do as a result of your assessment. This could include the prescription of meds, the collection of specific labs or imaging studies, and the simple day-to-day stuff you will do.

  It is worth noting that this section also includes a problem list as well. In fact, many clinicians will not separate the Assessment and the Plan sections. Rather you will often see an A/P section which would incorporate the overall assessment description and then a problem list and plan, as seen in the example below.

Example:

63 yo AAM admitted for GI Bleed

① GI Bleed – transfused 2 units this AM, repeat afternoon H/H, GI service following

② Obesity – dietician consulted to see patient during inpatient stay

③ HTN – continuing home meds HCTZ and Lisinopril

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Central lines, drains, SCDs…etc). And, just like with the vitals, you may have special "call instructions" here as well, but again, if it's worth a nurse calling you about, it's worth you reiterating that desire to them directly.

D—Diet

Some patient classes will have a specific diet. For example, most hospitals have special menus for diabetics, cardiac patients, renal patients…etc. But you may also have to address NPO statuses here and for patients receiving enteral or parenteral nutrition.

I—IV Fluids

This could probably be its own section in this little guide, but rest assured, you'll get the hang of this pretty quickly.

S—Special Studies

This is where you'd order any of the traditional tests you might think of. Imaging studies, EKGs, Echos, EEG, EGDs, cultures, urinalyses… they're all fair game here. Some also include consults here, but again, this should always be done yourself.

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The Op Note

Basic Info:

Patient Name, Hospital ID, DOB, Patient Location

Date of Admission, Date of Procedure

Pre-operative Dx

Post-operative Dx: often, "same" here will suffice but it won't always be the same

Procedure Performed

Surgeon +/- Resident surgeon

Anesthesia

Fluids

Estimated Blood Loss (EBL)

Urine Output

Drains

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M—Medications

You can refer to the next section as far as how to write prescriptions. However, here, just remember the types of things that may need to be addressed.

(anti-GI Ulcer, anti-DVT, anti-nausea, anti-pain, anti-biotics) are all very commonly encountered med types in hospital patients

A—Allergies

Allergy and the reaction

L—Labs

There is sure to be some overlap here and in the Special Studies section. It will likely depend on who you are working with. Be sure to remember this as orders for how you want your labs drawn. For example, if you want morning draws for CBC and CMP, be sure to enter that.

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CLINICAL SIGNIFICANCE

As consequence of these findings, the author has developed an instructional manual to mitigate deficiencies that may exist in writing these types of patient care notes. This instructional manual was designed for junior medical students to use as they get acclimated to the variety of notes they will encounter during their clinical clerkships. The materials associated with it are designed to be a 'pocket guide,' and provides them with an overview and example of multiple patient note types, including 'SOAP' notes, admission orders, operative reports, and prescription writing.

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