Case 14

Notes are inaccurate, too long, and do not contain documentation for billing even after feedback

Kara is an intern on her second inpatient wards rotation. She has been doing well clinically and is prepared for rounds each day. However, after your first day on service, you notice that her notes regularly contain outdated and inaccurate information about her patients (for example, level of respiratory support or labs), and her notes are very extensive, reading as a narrative of the entire hospital stay rather than focusing on the current active issues and changes in management for the day. She also routinely leaves out family history and review of systems from her admission history and physicals. You use this as an opportunity to review note writing principles with the team, but even after this discussion, Kara's notes do not change and continue to contain irrelevant and incorrect information.

Author: EG

Feedback Script

Case 14 – Notes are inaccurate, long and poor documentation

Step 1: Action Identify the Trigger Behavior • *Describe specific examples*	Notes contain inaccurate, irrelevant, and incomplete information. There is excessive content in her notes.
Step 2: Subcompetency Identify Milestone-based correlation • *Correlate behavior to milestone/EPA anchor*	PC1: Gather essential and accurate information about the patient – Level 2 PBLI4: Incorporate formative evaluation feedback into daily practice – Level 2 PROF5: Trustworthiness that makes colleagues feel secure when one is responsible for the care of patients – Level 1.5
Step 3: Evidence Target High Yield Feedback Points • *Real issue behind behavior* • *Identify impact of behaviors*	• Accurate and complete documentation is essential for patient care. • While it may be convenient (and efficient) to keep detailed (and long) information in progress notes, this type of documentation makes it challenging for other members of the care team to determine the most relevant information for the patient's current plan of care.
Step 4: Script Create Brief Script • *No more than 3-4 sentences* • *Neutral language* • *Focus on behaviors and actions*	Kara, I've noticed that your notes often contain information that is incorrect, outdated or no longer relevant to the current plan of care. For example, your notes have stated that Patient X has been on oxygen support for the last 3 days, when s/he has been on room air for the last 48 hours. Documentation is an important aspect of communication between care team members and if data is incorrect, this can lead to mistakes in patient care. Additionally, accurate notes are our professional responsibility as providers. Documentation is also used to support our professional billing codes and incomplete data (such as incomplete review of systems or absence of social or family history) can impact your ability to accurately bill for your services in the future.

Step 5: Strategy Describe Possible Plan for Improvement • *Create 1-2 specific methods for improvement*	• When writing your daily progress notes consider what the major aspects of your patient's plan of care for the day are and review your note to assess whether this message is clear. • As you document, consider how each piece of information you include shapes the narrative for your patient's care. Ask your attendings and/or senior residents to review your notes with a focus on including accurate and relevant information.

Author: EG