**Appendix 4**

**Improving Resident Progress Notes in the Electronic Health Record: Audit Tool Manual**

\*\*\*Questions 1-13 are to be recorded only from the information found in each progress note. See each question for further explanation of its intent.

NOTE: SEVERAL QUESTIONS INLCUDE THE WORD “CLUTTER” OR “NON-CLUTTERED”. A WORKING DEFINITION OF “CLUTTER” IS ANY ADDITIONAL DATA NOT ENDORSED AS PART OF THE BEST PRACTICES RECOMMENDATIONS AND THAT IS NOT EXPLICITLY DISCUSSED AS RELEVANT TO THE PATIENT’S CARE IN THE ASSESSMENT AND PLAN SECTION OF THE NOTE.

**1. Does the note header include the name of the service, author, and training level of the author? Y/N**

**NOTE: The header of the note refers to the header that is part of the progress note itself, NOT the header that is generated via Epic when printing the note.**

The author’s title should identify the service (e.g. Pediatric Hospitalist Red, Pediatric Pulmonary, etc) and training level of the author (e.g. Family Medicine PGY2, Cardiology Fellow, Pediatrics PGY1/Intern).

All elements must be present to answer “YES” to this question.

**2. Does it appear that the subjective/interval history section of the note was newly written (i.e. not copied in its entirety from the previous note)? Y/N**

You will need to compare today’s note with the previous day’s note to answer this question.

The subjective/interval history section may not be labeled as such but the author should include a section outlining the events of the last 24 hours.

To receive an answer of “YES”, the subjective/interval history should appear to be newly written.

Answer “NO” if it appears that the subjective/interval history is an exact duplicate of the previous day’s interval history. If the subjective/interval history appears to have been copied in its entirety from the previous day with additional information added, you should still answer “NO” to this question. Best Practices state that the narrative “should not be copied from the previous day’s note and should not be an entire history of the patient’s stay.”

**3. Is the vital signs section non-cluttered? Y/N**

To receive an answer of “YES”, the author should state “Vital signs from the last 24 hours have been reviewed and are pertinent for…” or similar language and/or include only selected vital signs. It is also acceptable to use the .vs smart link which pulls in only the last recorded set of vitals (temp, RR, HR, BP, pulse ox) OR the .vitalsminmax smart link which pulls in the min/max values of temp, pulse, RR, and BP over the last 24 hours. It is acceptable to state “…are pertinent for…” and to include one set of vitals.

Answer “NO” if multiple sets of vital signs are included or if any ERROR messages appear in the note such as “No Data Recorded”.

**4. Is the entire medication list included in the note?**

NOTE: WE DO NOT WANT THE ENTIRE MEDICATION LIST INCLUDED IN THE NOTE. THE ANSWERS TO THIS QUESTION ARE THE REVERSE OF ALL PRIOR QUESTIONS!

To receive an answer of “NO”, the author should include only selected medications OR include the medication list at the END of the note (after the assessment and plan).

Answer “YES” if the entire medication list is included in the body of the note (anywhere except after assessment and plan)

NOTE: It is not necessary for you to compare the written med list with the MAR or other parts of the chart to determine if the entire list has been included. This can often be visually determined by looking at the format of the medication list. If it appears in “tall boy” font and strangely formatted, it is likely the entire list. If it appears in the same font as the rest of the text, it is likely a select list.

**5. Is the I/O section non-cluttered? Y/N**

To receive an answer of “YES”, the author should state “pertinent I/O (input and output) values include…” or similar language and/or include specific input and/or output measures that are important in clinical decision making (e.g. drains) OR not include I/O data at all.

Answer “NO” if I/O section contains tables or lists of I/O data without comment on relevance for that patient.

**6. Does it appear that the physical exam was newly written (i.e. not copied in its entirety from the previous note)? Y/N**

You will need to compare today’s note from the previous day’s note to answer this question.

To receive an answer of “YES”, the physical exam should appear to be newly written. As long as the exam is not an exact duplication, the answer to this question may be “YES”.

Answer “NO” if it appears that the exam is an exact duplicate of the previous day’s exam findings.

**7. Is the lab section non-cluttered? Y/N**

To receive an answer of “YES”, the author should state “All recent labs have been reviewed. Pertinent labs include…” or similar and/or include specific lab test results. Similar language is also acceptable. It is also acceptable to include NO lab test results.

Answer “NO” if it appears that the author has included labs indiscriminately (I.e. long lists/tables of lab results) OR there are error links in the note (e.g. no result found for this basename).

NOTE: You do not need to compare the lab results section to the orders written for that day to determine if the author included all labs or just a selection. This may be a gestalt answer. If it appears cluttered and difficult to read, answer “NO”.

**8. Is the imaging (radiology) section non-cluttered? Y/N**

To receive an answer of “YES”, the author should state, “Recent imaging studies have been reviewed and are notable for…” or similar language, provide their OWN interpretation of the study, or include no radiology results.

Answer “NO” if it appears that the result/reading has been copied and pasted verbatim from PACS (this will often be evident in that there will be a different format/font)

**9. Does it appear that the assessment was newly written (i.e. not copied in its entirety from the previous note)?**

You will need to compare today’s note from the previous day’s note to answer this question.

To receive an answer of “YES”, the assessment may contain a **brief** summary statement identifying the patient and the reason for hospitalization (e.g. Jacob is a 3 month old boy admitted for fever). The remainder of the assessment should appear to be ENTIRELY newly written as compared to the previous day’s note.

To receive an answer of “NO (partially copied)”, the assessment may have some elements that are copied from the previous day’s note, but should include SOME new elements with additional information.

To receive an answer of “NO (copied in its entirety)”, the assessment must be an EXACT duplication of the previous day’s assessment with NO new elements added.

**10. Does it appear that the plan was newly written or partially copied with new information added?**

You will need to compare today’s note from the previous day’s note to answer this question.

To receive an answer of “YES”, the plan should appear to be ENTIRELY newly written OR to have some elements that are copied from the previous day’s note but also include SOME new elements with additional information.

Answer “NO” if the plan appears to be an EXACT duplication of the previous day’s note with NO new elements added.

**11. If the ASSESSMENT includes abnormal lab values, is there also an accompanying diagnosis? (e.g. inclusion of “patient has hemoglobin of 6.2, also includes diagnosis of anemia)**

To receive an answer of “YES”, ALL labs included in the ASSESSMENT section of the note should have an accompanying diagnosis OR no labs are mentioned in the assessment.

Answer “NO” if any labs are included in the assessment WITHOUT an accompanying diagnosis (e.g. creatinine 3.0 without concomitant mention of renal failure)

NOTE: It is not necessary for you to determine the clinical appropriateness of the accompanying diagnosis or the level of detail included. As long as there is some narrative comment/interpretation of the meaning of the lab result, the answer should be “YES”.

**12. Is additional visual clutter prevented by excluding other objective data found elsewhere in the chart?**

To receive an answer of “YES”, the author should not include other extraneous data in the daily progress note that appears to be “boiler plate” (e.g. weight, pain scores, PEWS scores).

Answer “NO” if there is visual clutter as a result of other data being pulled into the progress note (e.g. past medical history, social history, current orders, etc.). You should not take visual clutter addressed in previous questions (e.g. labs, meds, I/Os, etc) into account when answering this question.

**13. Is the author’s name and contact information (pager, cell) included at the bottom of the note?**

To receive an answer of “YES”, all elements must be included.

Answer “NO” if any element is missing.