Documentation

Dr Rahul Gill

Hospitalist/Sound physicians

Associate program director

Internal medicine residency program,

THR Presbyterian Hospital of Dallas, TX

Documentation*

Best practice

CMS/Insurance

THR

Medico legal

Quality metrics

Templates *

New templates
.IMRESIDENCYHP
.IMRESIDENCYPROGRESSNOTES
IMRESIDENCYDCSUMMARY

Documentation

All notes

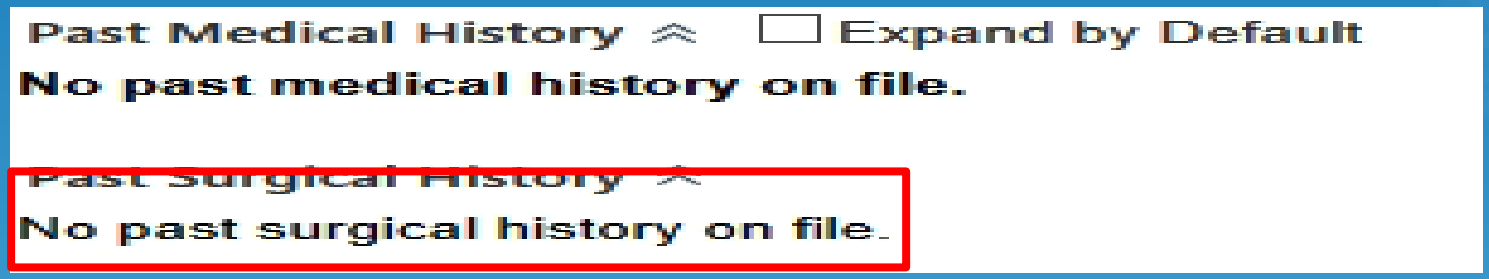
- Physical exam template

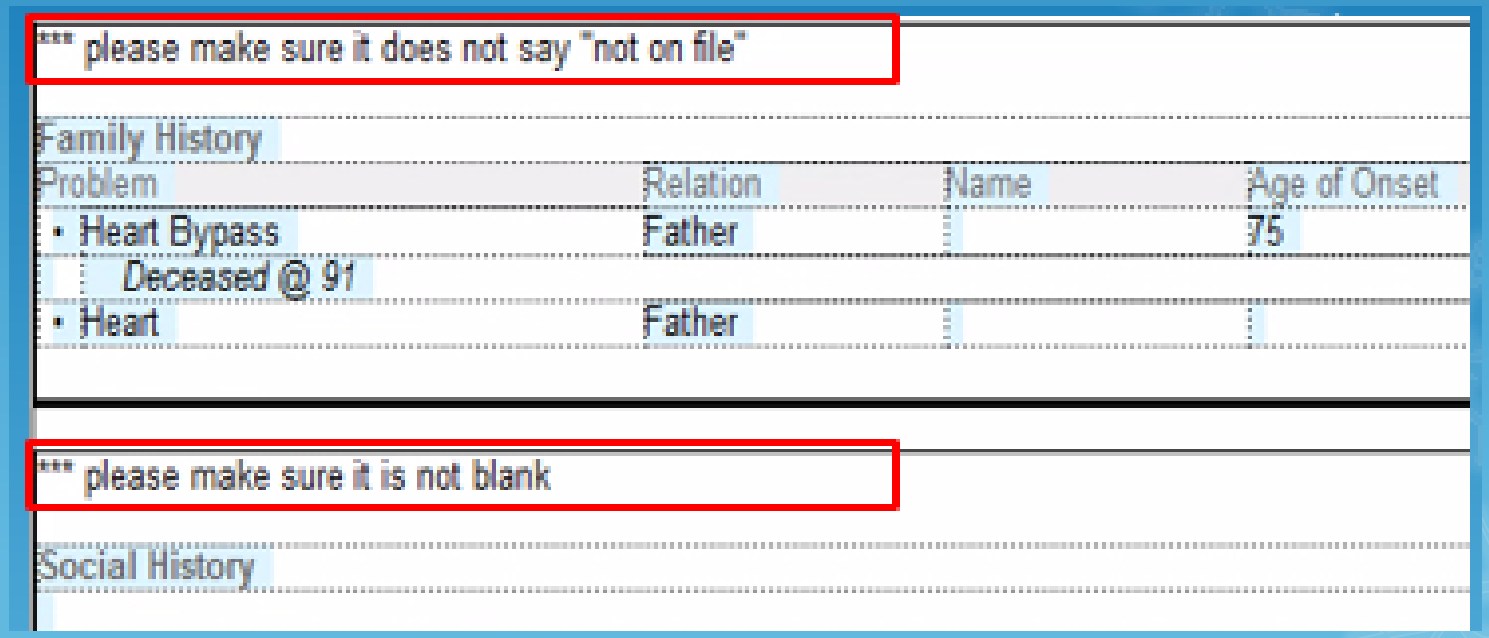
Physical Exam ***
General: No distress, cooperative
Eye- PERRL, no jaundice
ENT- MMM, clear oropharynx
Neck: Supple, no JVD
Lymphatics- No cervical lymphadenopathy
CV: Normal rate and Regular rhythm. No no murmurs or gallops appreciated
Pulm: Symmetrical chest movements, Lungs are clear to auscultation bilaterally. No adventitious breath sounds
GI: Abdomen without distention w/ Normoactive bowel sounds, soft, nontender, no hepatosplenomegaly apprecaited
MSK: No joint swelling or deformity.
Both LE Warm and without edema
Neurological: Awake and alert, A&O x3, cranial nerve 2-12 grossly intact, normal tone power and sensation in both upper and lower extremities, finger-to-nose without dysmetria on both sides, reflexes 2+ in both upper and lower extremities, gait normal
Skin: No rashes or lesions
Psych; Appropriate affect. Intact judgment and insight

Documentation

H&P

NO BLANK SECTIONS





Documentation

H&P

CODE status

Contact

FEN:
GIB prophylaxis ***
Code status: ***
MPOA is *** or Er medical contact ***

- Quality Improvement:
  - Foley in place? ***.
  - Has Padua VTE Risk Assessment been done: ***
  - Has VTE prophylaxis been ordered: ***
  - Lines: PIV *** PICC line, Central Line, Mediport, Dialysis Line

Anticipated length of stay: <2 midnights *** or > 2 midnights

Documentation

H&P

QI

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Documentation

H&P

ELOS

<2 MIDNIGHTS

VS

>2 MIDNIGHTS

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Progress notes

Chief complaint*

Internal Medicine Daily Progress Note

Patien

Medic

Date c

Age/Sex: 62 y.o. male

C/C or reason for admission- Palpations/SOB- Afib RVR

Subjective:

Progress notes

Chief complaint*

summary statement

Assessment/Plan:

Acute (on possible chronic) Congestive Heart Failure

- Patient is volume overloaded with 2+ BLE edema and bibasilar crackles. Has orthopnea, SOB, PND, and JVD.
- BNP of 1967; unknown EF. Likely 2/2 dietary nonadherence.
- Low salt diet, fluid restriction, strict Is/Os, telemetry, daily weights, O2 as needed.

Assessment/Plan:

XXYZ is a 62 y.o. male w has a past medical history of Congestive heart failure , CAD, Pand Thyroid disease who presents with

1. UGIB- 2/2 DU ulcer. S/p EGD. C/w PPI. HH stable post BT
2. Acute on chronic Systolic CHF w/ EF 35% 2/2 ICMP - exacerbated by Afib RVR. Volume status improved w diuresis. Holding diuresis due to hypotension 2/2 GIB. Monitor Volme status closely. I/O charting. TELE.
3. Afib RVR- New onset. Rate controlled. Cahd vasc 4. Holding AC due to GIB

Assessment/Plan:

XXYZ is a 62 y.o. male w has a past medical history of Congestive heart failure , CAD, Pand Thyroid disease who presents with new onset AFib RVR leading to exacerbation of CHF. He was started on AC in house and developed Melena> underwent EGD revealing DU ulcer.

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Progress notes

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summary statement

Rearrange problem list on daily basis

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Progress notes

Chief complaint
summary statement
Rearrange problem list on daily basis

Qualify each problem

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1. Acute on chronic Systolic CHF w/ EF 35% 2/2 ICMP - exacerbated by Afib RVR. Holding diuresis due to hypotension 2/2 GIB. Monitor Volme status closely. I/O charting. TELE.
2. Afib RVR- New onset. Cahd vasc 4. Holding AC due to GIB. C/w BB as tolerated by BP
3. UGIB- 2/2 DU ulcer. S/p EGD. C/w PPI. HH stable post BT
4. AKI- 2/2 CRS. Holding diuresis currently as above. monitor

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2. Afib RVR- New onset. **Rate controlled now.** Cahd vasc 4. Holding AC due to GIB
3. UGIB- **Resolved.** 2/2 DU ulcer. S/p EGD. C/w PPI. HH stable post BT
4. AKI- **improving.** 2/2 CRS. Holding diuresis currently as above. monitor

Progress notes

Chief complaint
summary statement
Rearrange problem list on daily basis
Qualify each problem

QI

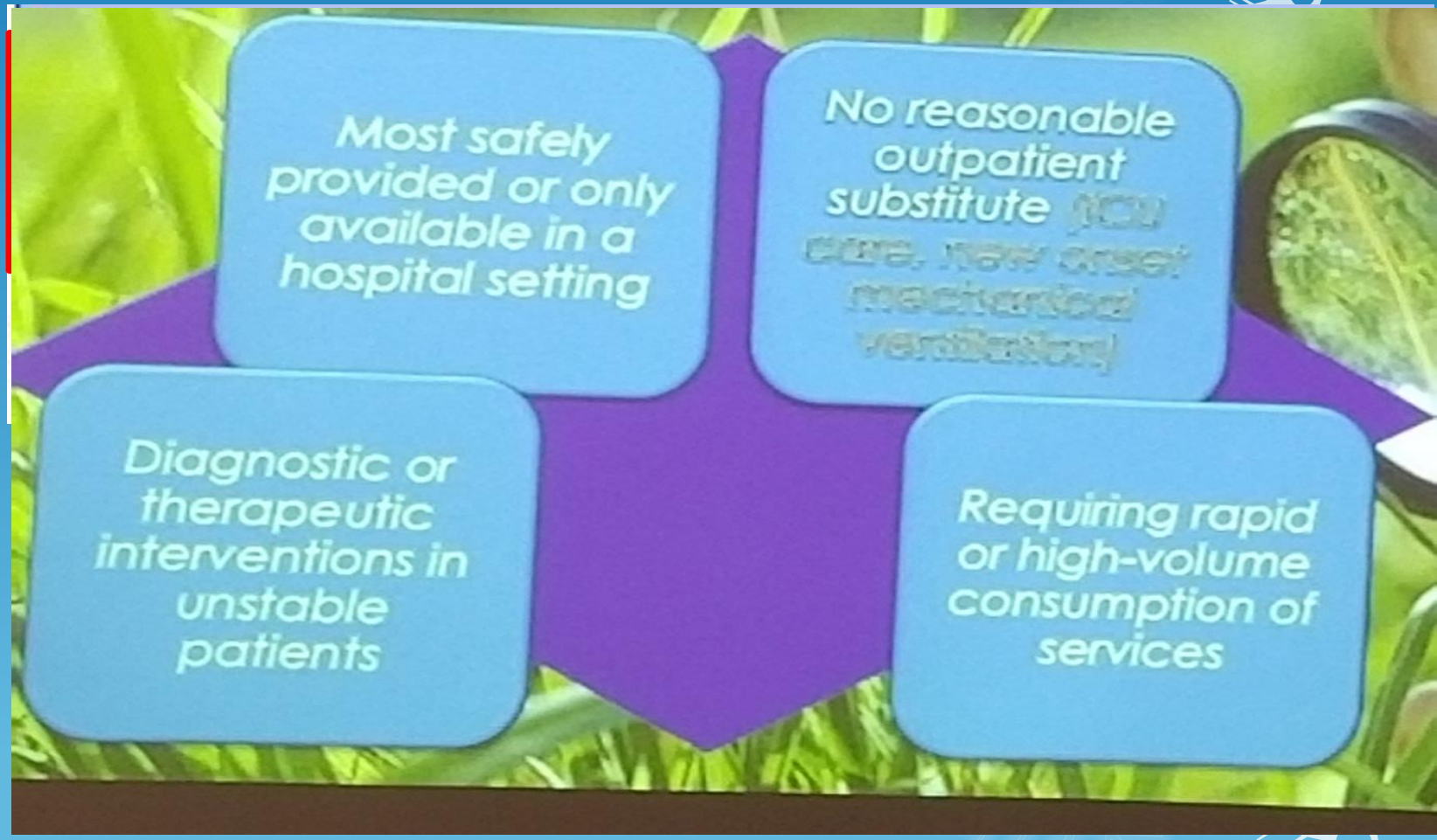
FEN:
GIB prophylaxis ***
VTE prophylaxis ***
Code status: ***
MPOA is *** or Er medical contact is ***
Foley in place? ***.
CL/PICC in place? ***

Progress notes

Chief complaint
summary statement
Rearrange problem list on daily basis
Qualify each problem
QI

ELOS

Reason for continued hospitalization



Progress notes

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summary statement
Rearrange problem list on daily basis
Qualify each problem
QI
ELOS
Reason for continued hospitalization

Expected NSOC(next site if care)

Reason for continued hospitalization: ***

Anticipated length of stay: *** days

Expected NSOC- ***

Home> Home w/ HH > SNU> acute rehab>LTAC

Discharge summary = within24 hrs of dc order

- DIAGNOSIS

Discharge Summary

Name:
MR#:
Room #
Admit I
Acct #:

Date:
DOB:
Age/Sex
Admittin

Discha
Physic

Discharge Diagnosis:

CAD
CONGESTIVE HEART FAILURE

Assessment/Plan:
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3. UGIB- **Resolved.** 2/2 DU ulcer. S/p EGD. C/w PPI. HH stable post BT
4. AKI- **improving.** 2/2 CRS. Holding diuresis currently as above. monitor

Discharge summary

- Summary and problem list

Discharge Diagnosis: Rt Nephrolithiasis, Rt Ureteral Calculi, Acute Kidney Injury

Procedures:
[7/19/2020] - Right ureteroscopy, holmium laser lithotripsy, placement right ureteral stent

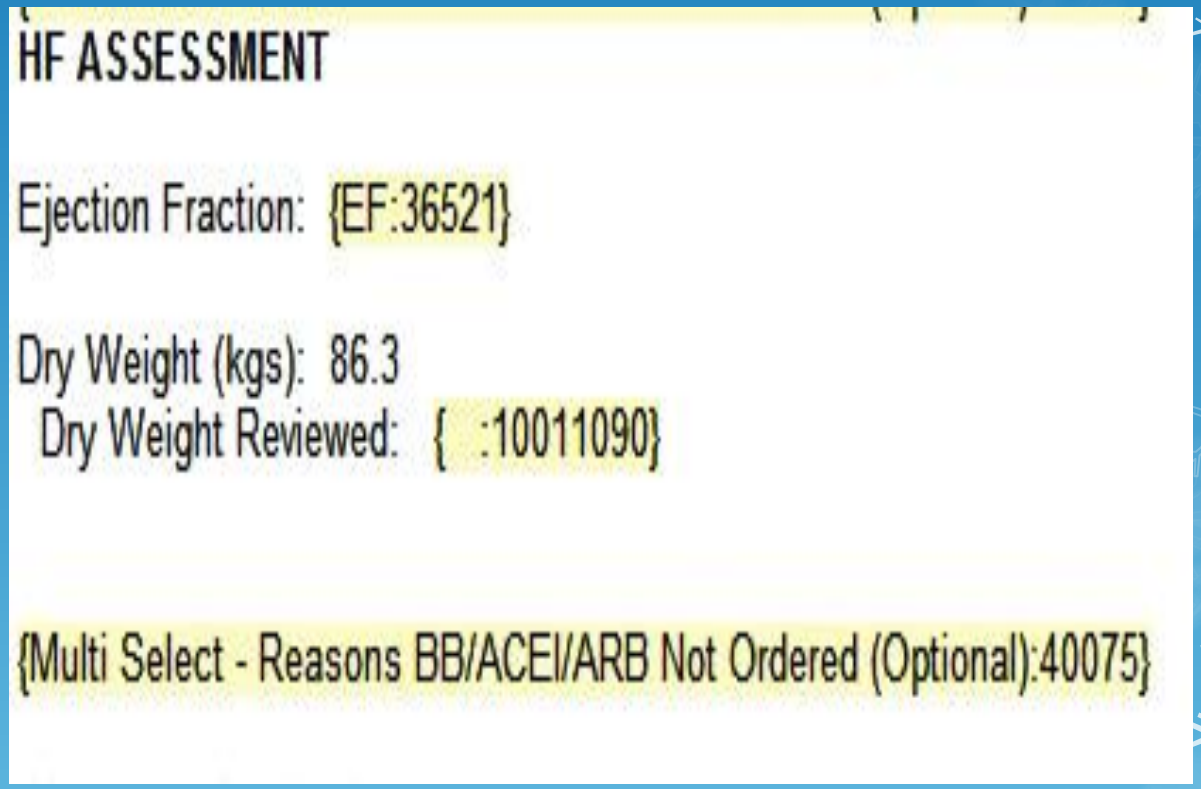
Discharge Condition: Stable and Improved

Hospital Course:
BRIEF HPI:
[redacted] MHx Nephrolithiasis (1982, 2000,2016), Hyperparathyroidism with imaging c/w parathyroid adenoma (2016), HTN, CAD s/p stents x4 on Plavix, A-fib/A-flutter on Eliquis s/p ablation who presented to ED the day prior to admission with a 4 day history of Rt flank pain. OSH CT Abdomen showed multiple stones in the Rt ureter, the largest of which measured 9 mm. He was sent home at that time with pain medication, flomax, and outpatient Urology follow up planned. He returned to the ED 7/18/20 with worsening Rt flank pain and CT imaging reveal three stones in the Rt Ureter. Labs on admission were significant for Cr 2.0 (from 1.6 on prior ED admission). He was treated with mlVF and PRN pain medication and underwent Rt ureteroscopy, holmium laser lithotripsy, placement of Rt ureteral stent on 7/19/2020. Surgical findings were significant for large, impacted rt midureteral stone and two smaller proximal stones. He was sent home with PO pain medication and instructed to follow up with Urology, Dr. Kadesky, in 3 weeks for stent removal. Urology will also follow up on 11 mm exophytic nodule arising from the posterior aspect of the mid pole region right kidney found on CT abdomen 7/18/2020. Eliquis was held the day prior to surgery and the patient was instructed to resume Eliquis the day after discharge. Patient says he will schedule outpatient follow up with PCP. Prior to discharge, his pain was significantly improved and he was able to void normally.

FULL HOSPITAL PROBLEM LIST:
Right Nephrolithiasis: in the setting of Hyperparathyroism and Hypercalcemia (10.4 on admission)
-CT Abdomen (7/18/2020) showed four stones ranging in size from 2-5 mm in the Rt Ureter, mild to moderate rt hydronephrosis, small calcified nonobstructing stones in the rt renal proximal collecting system
-on CT abdomen, persistent column of contrast in Rt ureter from prior CT with contrast made complete evaluation of size/number of stones unfeasible
-continued Flomax

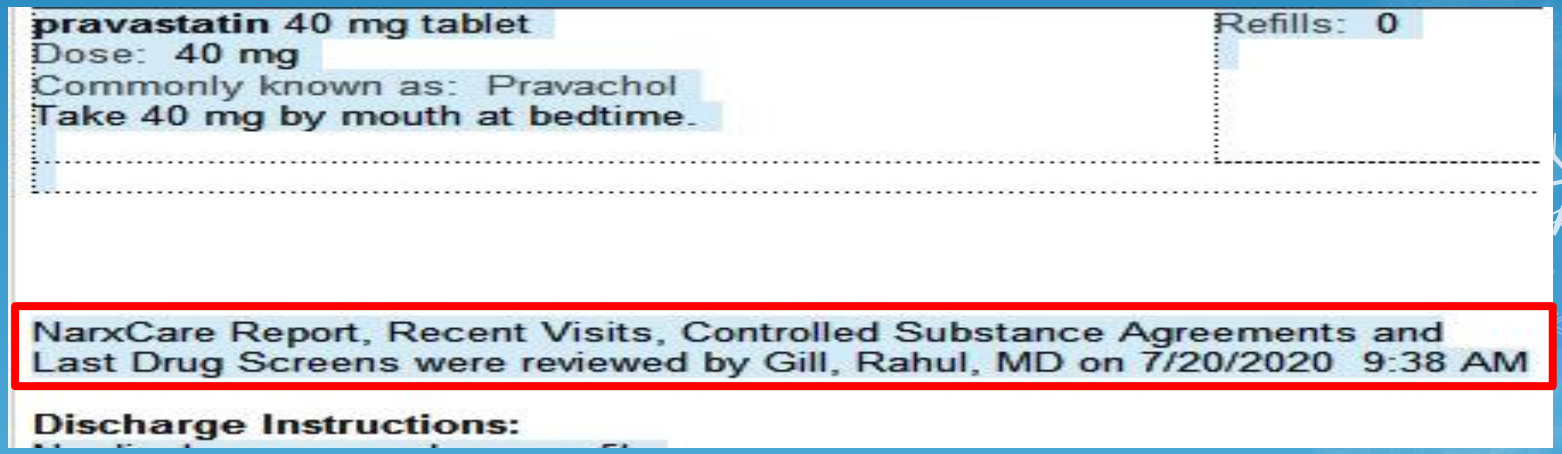
Discharge summary

- CHF DOCUMENTATION



Discharge summary

- TXPMP> Opiates



Cross cover

Timely documentation

"WHEN U SEE A PATIENT DOCUMENT IT"

ALL discussions w/ consultants/pts/family MUST be documented

Death note- time/date of death

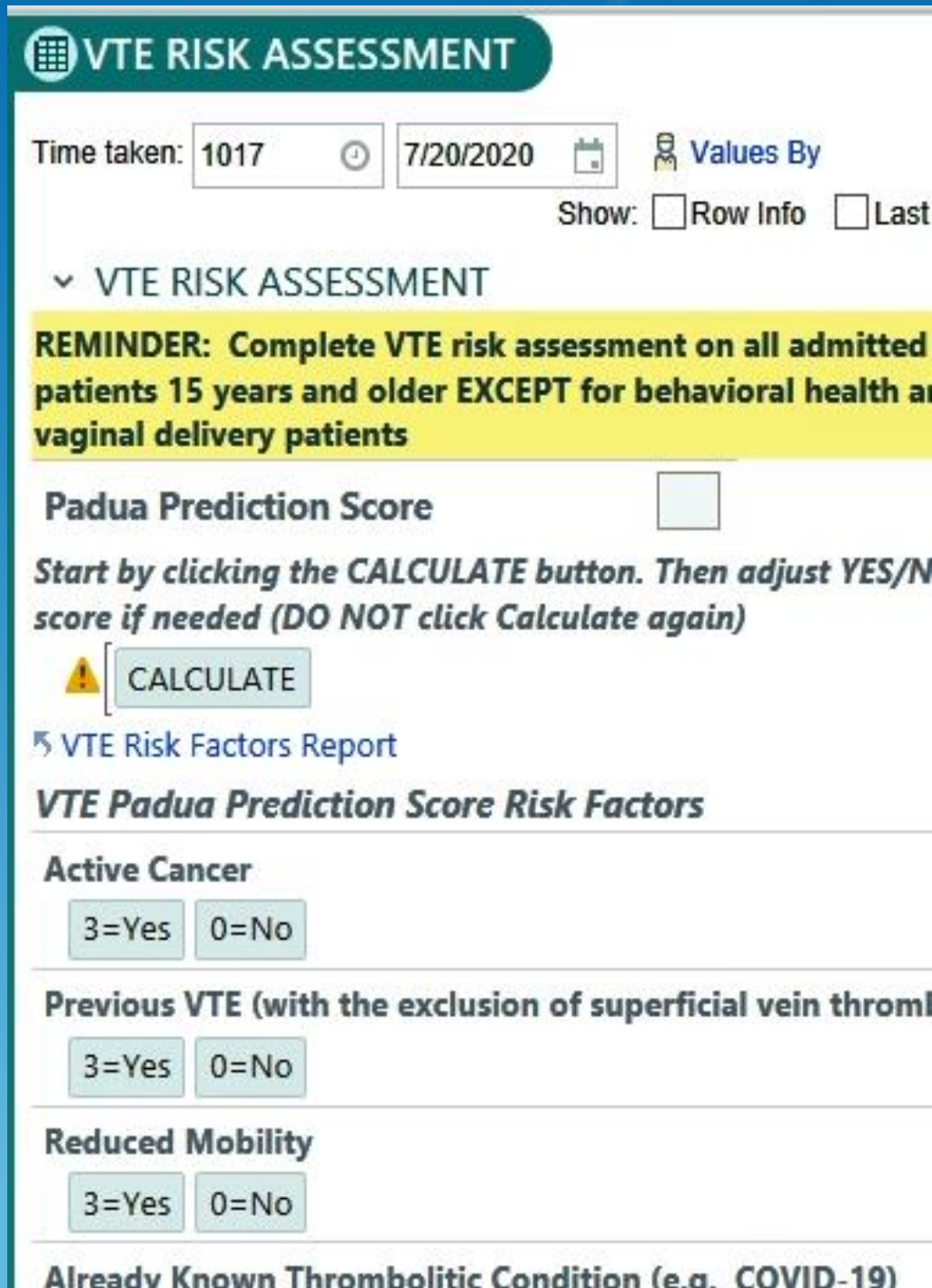
Quality metrics

- **OBSERVATION STATUS**
  - OBS HOURS

Attending Provider	PCP of Given Type	Patient Location	Length of Stay (Days)	Hrs in OBS	VTE Risk Score
TYLER, CLARENCE	CARROLL, JAMES MITCHELL	M22601	3	—	Low
GILL, RAHUL	RUDMAN, DAVID	H23001	5	—	High
GILL, RAHUL	GOMEZ-LOZANO, CESAR AUGUSTO	M23101	4	—	High
GILL, RAHUL	—	H41601	7	—	High
QURATUL AIN, FARHANA	DANG, PHUONG DENISE	J24401	4	—	Low
GILL, RAHUL	LEVIN, CHARLES BROOKS	H41801	2	—	High
HASSANEIN, MUHAMMAD H	—	THD ECHO	12	—	High
RIZWAN, ATIF	—	H42101	4	—	High
KUNIYIL, JESHEEJA K	BARNARD, JULIE RENEE	M22201	12	—	High
GILL, RAHUL	—	PHDH3NO	7	—	High
SALAND, KENNETH E	—	THD ECHO	1	—	Low
GILL, RAHUL	—	M43501	0	22	Low

Quality metrics

- **VTE Ppx** Add PADUA**



Heart Failure > .HF

EF
dry weight
Signs
Symptoms

HF ASSESSMENT
Signs supporting diagnosis of Heart Failure:
{CHF Signs - At least one needs to be documented:36515}

Symptoms supporting diagnosis of Heart Failure:
{CHF Symptoms - At least one needs to be documented:36519}

Ejection Fraction: {EF:36521}

Dry Weight (kgs): 112 kgs

HF ASSESSMENT
Signs supporting diagnosis of Heart Failure:
{CHF Signs - At least one needs to be documented:36515}

Symptoms supporting diagnosis of Heart Failure:
{CHF Symptoms - At least one needs to be documented:36519}

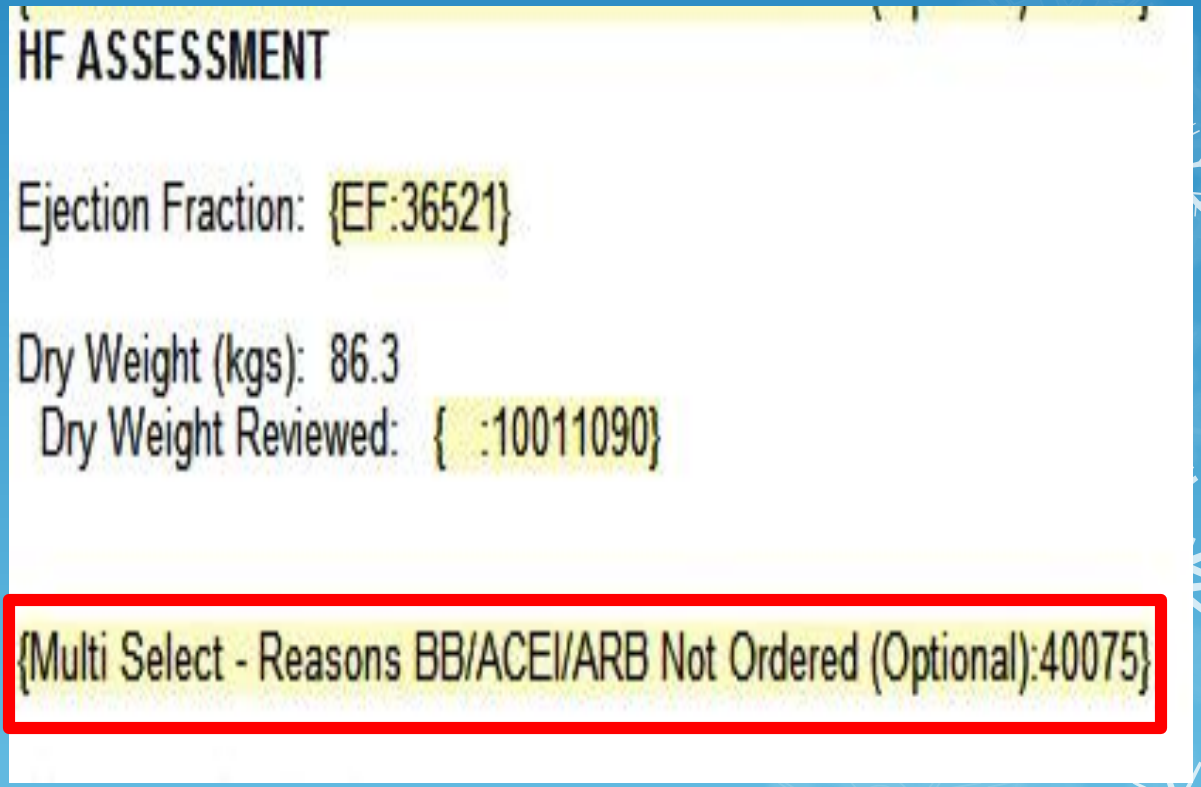
Ejection Fraction: {EF:36521}

Dry Weight (kgs): 112

- **Heart Failure** > .HF

EF
dry weight
Signs
Symptoms

New BB and ACEi***



Quality metrics

- **Sepsis**

Documentation >
.rgsepsis mx

Sepsis order set

- Sepsis/Severe sepsis*** secondary to *** with/without septic shock

Severe sepsis w/Hypo perfusion (SBP <0 or MAP <65, hypoxia, Dec UOP or inc creat, Inc LA,Oliguria,AMS, Low plat or inc INR, Inc TB)
IVF bolus 30ml/kg***

- Lactic acid level and repeat in 2 hrs if >2
- Cultures sent
- Broad Spectrum antibiotics ordered stat
- Will start vasopressors for MAP<65
- ESR, CRP
- VBG- Target Vo2 >70***
- Picc/CVC***

Exam: I have reassessed tissue perfusion after bolus given

Vitals: BP: 136/91 | Pulse: 60 | Temp: 97.6 °F (36.4 °C) | Resp: 18 | Weight: 99.9 kg (220 lb 3.8 oz) | SpO2: 98 %
CV: {CARDIAC:37728}

Quality metrics

- **Queries**

24 hrs to respond

Daily checkout:

Central lines/Foleys/ DVT ppx

Discharge orders

Before noon

Clean orders- No contingencies

Quality metrics

- **Patient satisfaction/ HCAPS-**

Resident autonomy vs attending responsibility

Resident plans vs attending plans

DOCUMENTATION

WHEN U SEE A PATIENT DOCUMENT IT

ALL discussions w/ consultants/pts/family MUST be documented

Biggest pitfall- copy /pasting notes

Chart deficiencies

In box messages

Thank you*

??????????????????