

Writing progress notes: 10 dos and don'ts

What to include in—and exclude from—
patients' medical records

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Progress notes must convey that the psychiatrist provided quality care and respected the patient's condition and wishes. Knowing what information to include—and what to leave out—can help you and your colleagues avoid a malpractice judgment.

Follow these 10 dos and don'ts of writing progress notes:

1. Be concise. Document all necessary information but avoid extraneous details, such as in this example:

“Patient moved to Kansas at age 4. Her parents separated when she was 6 and they moved back to Chicago, then reunited and moved to Indiana, where father took a job as a shoe salesman. When he lost that job, they moved back to Chicago and divorced for good. Mother remarried a fireman, who was an alcoholic; they stayed together for 2 years until ...”

Instead, simply write:

“Patient's childhood was chaotic with many moves; her mother remarried x 3. No physical or sexual abuse ...”

2. Include adequate details. Do not exclude information critical to explaining treatment decisions.

continued



Describe the symptoms the patient is reporting and the signs you see—or do not see.

This example offers insufficient detail:

“Patient’s parents told her that they just bought a new car. She recalled the first car they had gotten when she was little, and how that made her happy. She talked about the first car she owned. Plan: Add lithium ...”

By contrast, the following example explicitly describes signs and symptoms. Also be sure to include a short explanation when changing, discontinuing, or adding a medication:

“Patient reports her mood is much improved. She cannot recall what made her feel so depressed last week. She is hyperverbal, talking rapidly, gesticulating as she talks—much more animated, as compared to psychomotor-retarded presentation of last week, when SSRI was started. Assess: Bipolar switch. Plan: Add lithium, 300 mg bid, and titrate.”

3. Be careful when describing treatment of a patient who is suicidal at presentation. Your notes must contain clear, well-reasoned explanations for:

- discontinuing suicide precautions
- not hospitalizing outpatients who express suicidal ideation.

If the patient attempts or commits suicide shortly after the visit, your progress note may be your best—and only—defense against a malpractice claim. This example offers no convincing argument that the patient will not attempt suicide:

“Patient reports that he feels better. He denies suicidal ideation. He thinks the antidepressant is working. Nursing notes indicate no problems. He would like to get dressed and take a walk outside ...”

Instead, verbatim patient statements offer more-concrete proof that the patient wants to live:

“He said he is his family’s sole support and could never abandon them ...”

“He said it would kill his mother if he took his own life ...”

“She said suicide is against her religion ...”

Simply writing “No evidence of suicidal/homicidal ideation” raises the question of whether you asked the patient if he or she has considered suicide or just looked for a sign indicating suicidality. Always ask and record the patient’s exact response.

4. Remember that other clinicians will view the chart to make decisions about your patient’s care. Consider this example:

“Patient just moved to this area and requests amitriptyline and chlorpromazine. The risks of combining these medications were explained to him, but he insisted, so will order.”

If another provider is to grant the patient’s request, more details are needed:

“Patient states that he has been on every antipsychotic and antidepressant on the market—including the newest drugs—over 20 years. He says nothing works for him except this combination. The potential anticholinergic and other severe adverse effects associated with this combination were explained to him, and his responses indicated that he clearly understands the risks. He states, ‘These are the only drugs that have kept me from hearing voices and being depressed and suicidal. I want to stay on this combination.’”

Illegible notes frustrate others and inspire lack of trust in the doctor who wrote them

5. Write legibly. Many doctors are encouraged to write illegible notes as a defense against legal action. The reasoning: the defendant can testify to anything since no one can read the notes anyway.

Illegible notes annoy and frustrate the people who cannot read them and inspire a lack of trust and confidence in the doctor who wrote them. And they are not likely to fool a jury.

6. Respect patient privacy. Do not name or quote anyone who is not essential to the record. Identifying another patient by name or Social Security number—even the last 4 digits—is a breach of privacy. For example:

“Charlene claimed R2803 followed her into the rest room and raped her...”

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Related resources

- ▶ Selden BS, Schnitzer PG, Nolan FX. Medicolegal documentation of prehospital triage. *Ann Emerg Med* 1990;19:547-51.
- ▶ Bjorck JR, Brown J, Goodman M. *Casebook for managing managed care: a self-study guide for treatment planning, documentation, and communication (1st ed)*. Washington, DC: American Psychiatric Association, 2000.
- ▶ Wiger DE. *The clinical documentation sourcebook: a comprehensive collection of mental health practice forms, handouts, and records (2nd ed)*. New York: John Wiley & Sons, 1999.

DRUG BRAND NAMES

Amitriptyline • Elavil
Chlorpromazine • Thorazine
Lithium • Eskalith, others

DISCLOSURE

Dr. Roth reports no financial relationship with any company whose products are mentioned in this article or with manufacturers of competing products.

Did patient R2803 actually do this? What if Charlene's psychosis prompted her to make delusional claims about other patients and staff? If her case ends up in court, patient R2803 is named in connection with an unproven allegation. Naming R2803 in Charlene's chart identifies him as a psychiatric patient at that facility, thus violating his privacy.

If your patient makes accusations toward another patient, describe the alleged encounter this way:

"Charlene was upset over an interaction she described with another patient. Staff allowed her time to ventilate, and (name/dose of sedative) was given. The incident was addressed with the other patient's treatment team and staff ..."

7. Do not include complaints about other staff members, whether from the patient, staff, or a doctor.

Let's say a resident pages his backup attending but receives no answer. Entering in the patient's chart that "Dr. Smith was paged but did not answer" gives the impression that Dr. Smith is ignoring calls, when in fact any of the following may be true:

- the resident does not realize Dr. Smith traded on-call duty with another doctor

- the batteries in Dr. Smith's pager died
- or Dr. Smith was home, available by telephone, with his pager tucked away in his briefcase.

If the doctor on call cannot be reached, call another doctor—a supervisor or department head—and document your conversation with him or her. Do not identify the doctor who was not available.

Supervisors should address doctor availability issues the following day. Such issues do not belong in a patient's chart.

8. Document responses to and from other providers.

When consulting another doctor for advice, describe the encounter and identify the doctor by name. For example:

"Dr. Mark Jones advised me to accommodate the patient's request for discharge, because he has known the patient for many years and feels it is safe for the patient to come to see him at the clinic in the morning."

9. When disregarding a consultant's advice, clearly explain why. For example:

"Neurology consultant recommended stopping patient's antipsychotic due to risk of tardive dyskinesia. This patient, however, has been on numerous antipsychotics over the years, and this is the only one that controls his schizophrenia. Patient is aware of the risk of tardive dyskinesia and does not find it problematic. Patient is competent and understands the need to weigh potential side effects against the medication's benefits, and he prefers to continue the medication."

10. Never enter derogatory or pejorative statements about a patient. As psychiatrists, we must convey a sense of concern and respect for the patient, regardless of diagnosis and presentation.

Rather than entering, *"This patient is obviously lying about his history,"* instead write, *"This patient's version of his history is at odds with that in previous hospital records."*