

EM Basic- Documentation

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As always- read the entire triage note and triage vitals

- Acknowledge abnormal vital signs
- Important to read triage note, vitals, and nursing notes- you must acknowledge discrepancies between triage note and your history/exam

Example- In a patient with an ankle sprain, if they have chest pain documented in their chart but they deny it, you have to address it. Maybe it was a mistake during triage (Wrong chart? Errant checkbox?)

History of Present Illness

-4 to 6 sentences in length- tell a story of why the patient is in the ED.

Example:
45 year old male with chest pain of 4 out of 10 x3 hours. Sharp, non-radiating chest pain that started while at rest, resolved an hour later without intervention. No aggravating or relieving factors. Pt denies SOB, N/V, diaphoresis abdominal pain, no history of similar pain in the past.

- Has a clear and succinct history
- Addresses all OPQRST questions about pain
- Past Medical History as relevant to chief complaint
 - Could say this patient has NKCAD- No Known Coronary Artery Disease
 - If the patient had a history of MI, may want to mention that in HPI since it relates directly to chief complaint

Example:
60 year old male with hypertension and STEMI 1 year ago with chest pain that woke him up from sleep approximately 1 hour ago. Pt describes substernal chest pressure with radiation down his right arm that is similar to his previous MI with diaphoresis and nausea. Stents placed 1 year ago with his previous STEMI.

Past Medical History

Past Surgical History

Medications

Allergies

Annotate each section completely

- If done already in triage, double check with patient for accuracy

Brief Social History

- Ask every patient if they smoke or drink and how much
- Technically you are supposed to ask every patient about drug use but that seems extreme for ALL patients

Sexual History (as needed for chief complaint)

- Not relevant in most patients but document one if this is relevant to chief complaint (GU complaint, vaginal discharge, or female abdominal pain)

Reality check- Social history is not relevant for most patients we see in the ED but its necessary for complete billing and reimbursement. While this should not be a focus as an EM novice, its important to start good habits early when your future employment depends on reimbursement. It stinks that this is the case but its reality

Review of Systems (ROS)

- First- if patient can't give a ROS because they are unconscious, critically ill, or have dementia then note this in the chart so you don't have to do ROS
- Ask all patients a general head to toe ROS
 - “Do you have fever, chills, headache, sore throat, chest pain, or abdominal pain”
- Check off ROS systems that are positive and then check “All other systems review and otherwise normal”
AKA the biggest lie in medicine
(but you have to play the game...)

Physical exam

- Make sure to fully document each portion of your exam
 - You are doing a head to toe exam on everyone, right?
- Check off the exam findings that you complete
 - Cross off those findings that the patient doesn't have that are relevant to the chief complaint

DO NOT DOCUMENT EXAM FINDINGS THAT YOU DIDN'T DO- don't get checkbox happy!

- Frequent mistakes- things not examined
 - Checking off "Tympanic Membrane" normal when you didn't look in the ears
 - Checking off a GU/rectal exam when you didn't do one

Neuro and Psych exam

- Need to include this section in order to fully bill but does every ankle sprain need a cranial nerve exam? What about the psych exam?
- Rationale- if a patient with an ankle sprain walked into the room under their own power, is speaking to you clearly, and is not altered then you can be confident that neuro and psych exams are normal and you can check it off as normal

Documenting the area of interest

Example- abdominal pain

Important to document positive findings

- Soft, non-tender abdomen

Important to document negative findings as well

- No rebound, guarding, or peritoneal signs

Medical Decision Making

Describe the patient

Describe what you did for the patient

- Testing and treatments

What you have ruled out

- AKA what you don't think it is

Patient's ultimate disposition

- Home, admission, transfer to another facility

PEARL: In general, patients going home need longer notes than those who are admitted. Sicker patients get longer note than not-so-sick patients

Example MDM of a patient being discharged

20 year old male with N/V/D, non-concerning abdominal exam. Zofran (ondansetron) and PO fluids, pt PO tolerant, normal vital signs. Repeat abdominal exam normal. Doubt apy, chole, perf, obstruction based on history and physical and multiple exams. EC re: RP and need for follow-up.

PEARL: "EC re: RP" is my own abbreviation for "Extensive Conversation Regarding Return Precautions"

Example MDM of patient being admitted- not-so-sick

50 year old male with chest pain. CXR, EKG, and labs negative. ASA given. Admit for low risk chest pain rule out

Documenting interactions with consultants

ALWAYS WRITE DOWN THE CONSULTANT'S NAME (not just "medicine on call") AND THE TIME YOU CALLED EVERYTIME YOU SPEAK WITH A CONSULTANT

- This may be very important later on if there is a question about your care.
- Record all recommendations from the consultant in regards to admission, outpatient followup, or any recommended diagnostics or treatments
- Having a difficult time with a consultant
 - Stay professional, be factual, don't editorialize in the chart
 - If it's a time sensitive chief complaint, clearly document times

Giving Good Discharge Instructions

- Have a final conversation with ALL patients you are discharging
- What you think the patient has, what you think they don't
- What symptoms to return to the ER for
- Come back for new symptoms or if they are not better
- Make sure the patient knows that you want them to come back if they are worse in any way
 - Don't ever make the patient feel that they are a burden for coming back to the ED- its what you want them to do!
- Talk about all medications you are prescribing
- If you are prescribing medications that will make the patient drowsy, tell the patient not to drink alcohol or drive while using those medications
 - Document these "sedation warnings" in the chart
 - Can abbreviate this as "SW given"
- Tell the patient when they need to follow-up with their primary care doctor
 - Good options are 1-2 days, 2-3 days, or 3-5 days
 - Come back in 12 hours for an abdominal pain recheck?
 - Specific followup with a specialist?
 - Tomorrow with orthopedics?
 - Tomorrow with pediatrics?
 - Call the office for appointment or walk-in?

- Do you have any questions?
 - IMPORTANT!- make sure everything is clear to the patient at their family

Discharge instructions

PEARL: NEVER rely on the pre-printed discharge instructions- always type/write out your own

Type in the same thing

Return to the ER for X, Y, Z (worrisome symptoms), new symptoms or ANY other concerns

Take (medications) as directed

-Spell out exact children's acetaminophen/ibuprofen doses based on weight

As needed "NO DRIVING OR ALCOHOL WHILE TAKING (sedating medication)"

Followup with your family doctor in (1-2, 2-3, or 3-5 days) WITHOUT FAIL

This is basically your discharge conversation in written form. Some may say all of this is overkill but I think it's good practice- including the capitalization of key words and phrases.

Some useful chart abbreviations:

NKCAD: No Known Coronary Artery Disease

N/V/D- Nausea, vomiting, diarrhea

Chole- Cholecystectomy

Appy- Appendectomy

Obst- Obstruction

Perf- Perforation

SW given- Sedation Warnings given

EC re: RP- Extensive Conversation regarding Return Precautions

R/o- rule out

Cath- usually short for "cardiac catheterization"

R/G/PS- Rebound, guarding, peritoneal signs (abdominal exam findings)

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