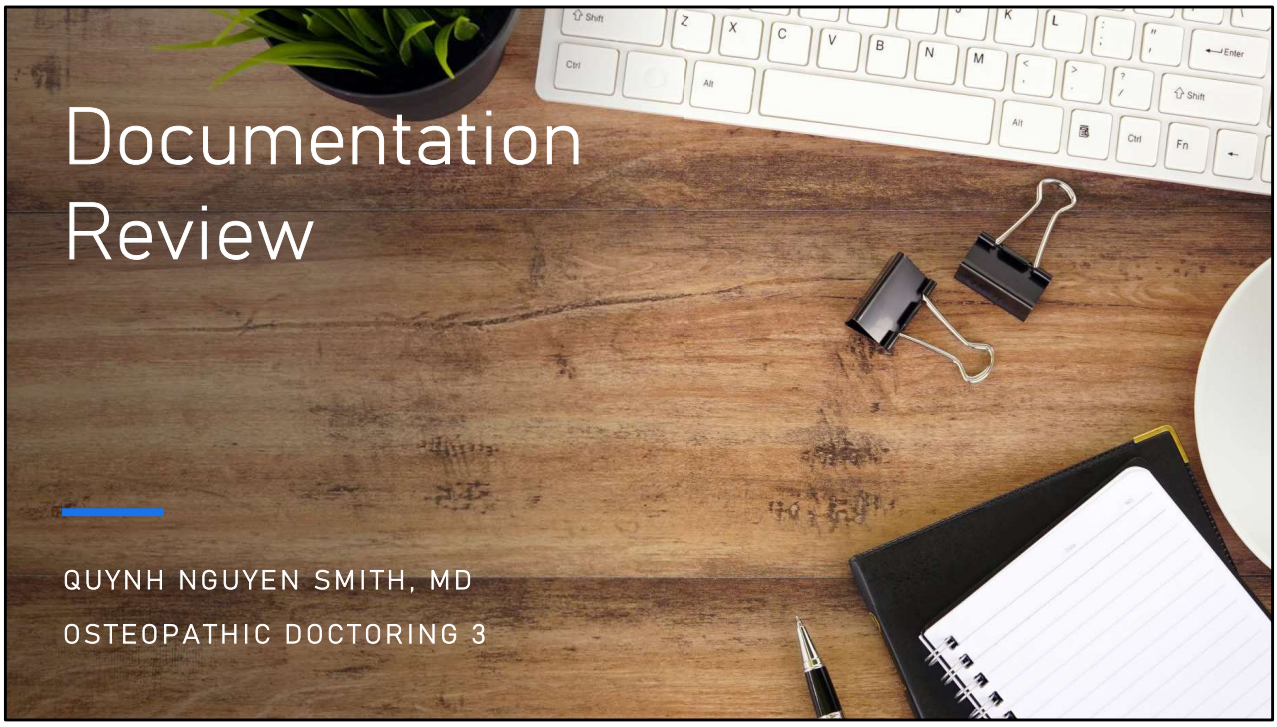

Documentation
Review
QUYNH NGUYEN SMITH, MD
OSTEOPATHIC DOCTORING 3

Objectives

Understand	Define	Differentiate
Understand the importance of proper documentation	Define the components of a SOAP (Subjective, Objective, Assessment, Plan) note	Differentiate among the various types of SOAP notes · Acute/sick visits · Wellness/preventative visits · Chronic disease managements visits · Inpatient/outpatient notes

Why do we document what we do?

- Important to COMLEX
- Relevant to role in rotations
- Crucial to job as physician
  - Legality in medical-legal system
  - Patient care consistency for self and peers
    - Prevents medical errors
    - Improves transitions of care
  - Patient rights to information

Boards Question/Case example

A 69-year-old male presents to the emergency department complaining of abdominal pain. Vital signs reveal a blood pressure of 100/68 mmHg and heart rate of 121/min. Physical examination reveals a pulsatile abdominal mass. Bedside ultrasound reveals a leaking aortic aneurysm. While the medical team prepares the operating room and calls for blood products from the blood bank, the physician explains the severity of the findings and the current plan to the patient. The patient responds, "I understand that the ultrasound shows that a large blood vessel in my abdomen is bleeding and that you recommend immediate surgery to fix the blood vessel and blood transfusions to replace the blood I am losing. However, my religion forbids me from receiving blood, so I don't want any blood even though I understand that I may die without it. I am ok with having the surgery as long as you promise not to give me blood." The physician knows that without a blood transfusion, the patient is unlikely to survive. The most appropriate course of action for the physician is to

A. Call the patient's spouse seeking consent for blood transfusions
B. Do everything possible for the well-being of the patient, including adminstering blood products
C. Refer the patient for immediate surgery without blood products
D. Request a psychiatric consult to determine if the patient has decision-making capacity
E. Since the patient's and the physician's understanding of the need for a blood transfusion differs, obtain the input of the hospital's ethics committee

Source: TrueLearn COMLEX Q bank

A 69-year-old male presents to the emergency department complaining of abdominal pain. Vital signs reveal a blood pressure of 100/68 mmHg and heart rate of 121/min. Physical examination reveals a pulsatile abdominal mass. Bedside ultrasound reveals a leaking aortic aneurysm. While the medical team prepares the operating room and calls for blood products from the blood bank, the physician explains the severity of the findings and the current plan to the patient. The patient responds, "I understand that the ultrasound shows that a large blood vessel in my abdomen is bleeding and that you recommend immediate surgery to fix the blood vessel and blood transfusions to replace the blood I am losing. However, my religion forbids me from receiving blood, so I don't want any blood even though I understand that I may die without it. I am ok with having the surgery as long as you promise not to give me blood." The physician knows that without a blood transfusion, the patient is unlikely to survive. The most appropriate course of action for the physician is to

A. Call the patient's spouse seeking consent for blood transfusions
B. Do everything possible for the well-being of the patient, including adminstering blood products
C. Refer the patient for immediate surgery without blood products
D. Request a psychiatric consult to determine if the patient has decision-making capacity
E. Since the patient's and the physician's understanding of the need for a blood transfusion differs, obtain the input of the hospital's ethics committee

Source: TrueLearn COMLEX Q bank

Patients who have decision-making capacity have the right to refuse life-saving treatment for themselves, and physicians must abide by these decisions.

Why do we document what we do?

- Important to document what happened in all cases and why
- For especially sensitive/rare/unusual, use patient quotes to provide reasons by physician decisions, such as refusal to provide blood products before major surgery
- When first starting to write notes, important to be as thorough as possible
- Overtime (as you progress through training), can fine-tune notes to make them more concise
- If it is not in your note, it did not happen!
- If it did not happen, do not put it in your note!

SOAP Framework

1) **Subjective**: information that is subject to patient's point of view (history; can also include chart review that includes information from other providers)
2) **Objective**: concrete facts (vitals, physical exam, labs, imaging reports, etc)
3) **Assessment**: Analysis of subjective and objective information (clinical reasoning including differentials)
4) **Plan**: What to do next (6-point plan permissible)

What is Subjective?

- *Dictionary* *Definitions from Oxford Languages (adjective)*

1. based on or influenced by personal feelings, tastes, or opinions.

- Allows others to understand the patient's experience
- Best written as a story, in patient's own words

Example:

Patient X: "My stomach hurts on the bottom"

--> DO paraphrase "X has pain on the bottom of the stomach" OR provide direct quote "X says "stomach hurts on the bottom.""

--> DO NOT report objective information as you would in your exam "X has suprapubic abdominal tenderness"

--> DO NOT interpret as you would in your assessment "X likely has a urinary tract infection"

Outline of Subjective

- **Chief complaint (CC)**: Answer to "what brings you in today" in patient's own words
- **History of Present Illness (HPI)**: Answers to your open-ended question (OLDCARTS, etc) in a story format. Relevant parts of past medical history, family history, ROS, and other parts of history can also go here. Should start with *"X is a __ year old with PMH of __ who is here for ___"*
- **Past medical history (PMH)**: Answer to "what medical problems have you been diagnosed with before"
- **Trauma History:** Includes, physical, sexual, and mental
- **Surgical history**: Answer to "What surgeries have you had and when"
- **Hospitalizations**: Answer to "What hospitalizations have you had and when"
- **Family History** (FH): Answer to "What conditions run in your family"
- **Social History**: Answers to questions related to exercise, diet, occupation, living situation, sexual history, drug use (review history taking directed study)
- **Allergies**: Record any reactions to foods, medications, latex as well as reaction
- **Medications**: Record prescribed and over the counter medications, supplements, including dose, frequency, indication and adherence
- **Review of Systems** (ROS): Answers to ROS questions as yes/no

The note is similar to how you would take the history; the patient may not answer questions in this order but the notes are generally documented in this order
OLDCARTS =
O - Onset: When did the symptoms start?
L - Location: Where are the symptoms located?
D - Duration: How long have the symptoms been present?
C - Character: Describe the nature of the symptoms (e.g., sharp, dull, throbbing)
A - Aggravating factors: What makes the symptoms worse?
R - Relieving factors: What makes the symptoms better?
T - Timing: Are the symptoms constant, intermittent, or worse at certain times of day or night?
S - Severity: How severe are the symptoms (e.g., on a scale of 1-10)

Turn this into sentences and proof read your story!

SUBJECTIVE	Score	Weight	Value
HPI is appropriate to the case (onset of symptoms, location, duration, character, alleviating/aggravating factors, radiation, temporal) and **10-12 relevant questions** for associated manifestations or symptoms listed in HPI instead of ROS.	0 3 4 5	3	
Relevant PMH, Trauma Hx, PSH, SH and FH is included ("reviewed, no changes" is acceptable – be sure to list anything relevant to CC/HPI here)	0 3 4 5	1	
Meds should list all including OTC– generic name, dose, mode of delivery (PO, IV, IM…), frequency, indication and **Allergies** (drugs/foods/latex) with reaction	0 3 4 5	1	
	SUBTOTAL		**/25**

What is Objective?

- *Dictionary* *Definitions from Oxford Languages (adjective)*

1.(of a person or their judgment) not influenced by personal feelings or opinions in considering and representing facts.

- Data gathered from taking vital signs (report as exact numbers), examining patient (use medical terminology), scores from questionnaires, patient information logs, and diagnostic labs and imaging (data should be exact and not editorialized)

EXAMPLE: The medical assistant takes the patient's temperature and it is 105 F

--> DO report under vitals: "Temperature 105 F"

--> DO NOT write interpretation "high temperature"

--> DO NOT write assessment "febrile illness"

Outline of Objective

- **Vital Signs** (exact values for weight, temperature, respiratory rate, heart rate, blood pressure, pulse oximetry)
- **Physical Exam** (Include all parts of the exam and DO NOT include parts you did not examine)

-General

-HEENT

-Cardiovascular

-Respiratory

-Abdominal

-Musculoskeletal

- **Osteopathic Structural Exam (see next slide)**
- **Labs** (exact values)
- **Imaging** (can pull in exact images, report dictations from specialists, or include own interpretation but must put a disclaimer)
- **Other studies**

Osteopathic Structural Findings

Severity Scale: 0=No Somatic Dysfunction (SD) 1= Minor TART 2= Obvious TART 3= Areas of greatest restriction		
Region Evaluated	**Severity** (0,1,2,3)	**Somatic Dysfunction** TART findings; Segmental Definition (ie, T5FR$_R$S$_R$, or L on R sacral torsion)
Head		
Cervical		
Thoracic		
Lumbar		
Sacrum		
Innominate		
Lower Extremities		
Upper Extremities		
Ribs/Diaphragm		
Abdomen/Other		

From "Guide to Osteopathic Medical Documentation" located on Canvas

OBJECTIVE			
Vital signs (BP, pulse, resp, temp, pain , weight, height, BMI) and **General impression** (e.g. distress level, A&O, nourished/developed or body habitus)	0 3 4 5	1	
Appropriate physical exam All systems examined should correspond to Primary/Working dx and Differential dx	0 3 4 5	2	
Osteopathic structural exam – regions examined all correspond to Primary/Working dx and Diff dx, all components of TART are listed for regions examined	0 3 4 5	2	
	SUBTOTAL		**/25**

Pop quiz: Subjective or Objective?

- X says they have had chest pain for 2 hours

Subjective

- There is reproducible pain upon palpation of the costochondral junction

Objective

- X likely has costochondritis

Neither! This is a differential as a part of the assessment

What is the Assessment?

An iterative process

Uses clinical reasoning to combine information from subjective and objective to deduce a working diagnosis

Includes differential diagnoses in order of likelihood based on given information

Interprets the current status of the patient

Review lecture on clinical reasoning

How to write an assessment

1) Remind the reader who and what you are talking about

- Should start with "X is a ___ year old ___ with a PMH of ___ who is here with __.

2) Discuss working diagnosis using clinical reasoning

- "My working diagnosis is___ because of ____and ___ from history and ___and ___ from physical findings."

3) Discuss 3 differential diagnoses using iterative process

- "My first differential diagnosis is __ because of __ from history and __ from physical findings"
- Move differentials higher up based epidemiology of patient, combined with incidence of diagnosis
- Do not forget life-threatening / serious DO NOT MISS diagnoses

Differentials prevent premature closure

Example

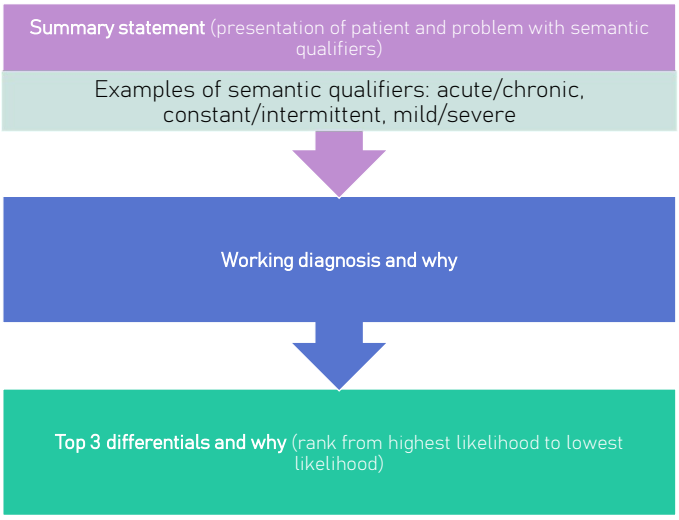
- *The 35-year-old female patient tells you she has pain at the "bottom of the stomach" for the past 2 days and it burns when peeing. She last stooled yesterday. She has vomited once. She was last sexually active a year ago. Exam is notable for 105 F and suprapubic pain upon palpation.*

What is your assessment?->

X is a 35-year-old female with no past medical history who presents with acute lower abdominal pain. The working diagnosis is a urinary tract infection due to suprapubic pain location and burning during urination from the history and tenderness upon palpation of suprapubic area and fever from the physical.

The first differential is gonorrhea due to the burning urination but is less likely because her last sexual encounter was a year ago. The second differential is constipation due to lower abdominal pain but less likely because this is not usually present with fever. A third diagnosis it could be that we do not want to miss includes appendicitis due to the fever, but this is less likely because of the location in the suprapubic area.

Outline of Assessment



DO NOT say you are ruling something out. If it is ruled out, it should probably not be in your top 3 differentials

Template for practical presentations, similar to documentation for "A" in SOAP

NAME is a AGE ___ GENDER (M/F), with a PMH of _____who presents with a CC _____for DURATION _____.

The WORKING DIAGNOSIS is _____ due to 1. _____ 2. _____ from history and 1. _____ 2. _____ physical.

The differential diagnoses (most likely to least likely) are (Need 3 with at least one reason why it is likely and why it is less likely)

1. _____ Reason: _____, _____

2. _____ Reason: _____, _____ and

3. _____ Reason: _____, _____

Clinical reasoning rubric*

ASSESSMENT / PLAN			
Summary Statement: includes name, age, gender, PMH, presenting with chief complaint with duration	0 3 4 5	1	
Appropriately supported primary/working diagnosis + ≥3 Differential Diagnoses for medical diagnoses with primary dx supported by at least 4 items from history and physical exam; Diff dx supported with two items from Hx and PE	0 3 4 5	2	
Somatic dysfunction is listed as at least one of the assessments.	0 3 4 5	1	
6 point plan for all assessments: Labs, Imaging/Studies, Meds, OMM, Pt Ed, Follow-up. ("not applicable" may be acceptable)	0 3 4 5	2	
ABCs (Autonomics, Biomechanics, Circulation and Screening) are listed as part of OMM plan along with what regions/segments are to be treated	0 3 4 5	1	
Follow up from last visit prior problem mentioned as an assessment, status updated (resolved, ongoing, etc), new plan if applicable	0 3 4 5	1	
	SUBTOTAL		/40

What is the plan?

- Explains what are the next steps in diagnostic process for the provider
- Explains what are the next steps for treatment for the patient
- Includes OMM
- Includes counseling/education

Outline of the plan

- Organize into separate problems
- Use Touro 6-point plan as a guide for each problem

1) Medications (include name, dose, route, frequency, indication)

2) Labs (name test and why)

3) Imaging (name test and why)

4) OMM (include ABCs)

5) Education (provide details medication side effects, return precautions, lifestyle modifications, resources, anticipatory guidance)

6)Follow up/referrals (specify when do you want to see the patient again, who else needs to see the patient)

Note that as you rotate in different rotations, some plans will be organized by systems and not problems. Stick with problems for now.

Outline of the plan

Additional "problems" include:

- Somatic dysfunction
  - Consent
  - Treatment plan
  - Medication
  - Education
  - Follow-up
- Health maintenance/ disease prevention
  - Screenings (can include labs and tests such as mammograms)
  - Immunizations
  - Due date of next wellness physical

Types of Notes

- Outpatient
  - New patient to establish care (complete comprehensive history and physical, including answers to questions on prior screenings, and focusing on any new problems)
  - Acute/sick visits (focus on specific chief complaint, with focused ROS)
  - Chronic disease management (follow up on conditions followed such as diabetes and hypertension, focusing on status of illness, adherence to plan, etc)
  - Wellness (similar to new patient visit above, with complete comprehensive history and physical, focusing on prevention and screenings)

Review history taking lab
Outpatient includes urgent care / clinic visits. ED notes can be similar to outpatient notes

Types of notes

- Inpatient
  - Admission history and physical (like acute/sick visit note, but will include section on emergency department course and plan while in hospital)
  - Progress note (provides an update from the day prior, including overnight events and new vitals, exam, labs, etc. for the current day)
  - Discharge note (summarizes the hospital course, including the reason for admission, and has physical exam and plan at time of discharge, with follow-up items patient and for primary care provider)

Reminders

- DO finish your note by the end of your day/shift (medical board tracks timeliness)
- Be very careful with copy and paste (medical errors arise)
  - If you do copy and paste, use quotes (even from your own prior notes)
- Consider using smart phrases and templates / artificial intelligence to save time AFTER you have mastered writing a comprehensive note by yourself
- Proofread your work!

TAKEAWAY POINTS

- Proper documentation is THE LAW
- Documentation is important to the boards, patients, providers, and lawyers!
- Remember that subjective information belongs in S, objective information belongs in O, and your assessment and plan follows
- While there are various note types, the SOAP format will still be used as the foundation for each one

Questions?

- See relevant materials on Canvas (Guide to writing notes, example notes, note template)
- Email Qsmith@touro.edu

References

- Bates' Guide to Physical Examination and History Taking 13th edition, Chapter 5: Clinical Reasoning, Assessment, and Plan. Sections: "Clinical Reasoning: Documentation", "Recording Your Findings", "Progress Note and Patient Problem List in the Electronic Health Record" (2020). Bickley, L. S., et. Al.
- Documentation Review powerpoint, Dr. Sue St Pierre. Fall 2022
- Osteopathic Medical Documentation: Guide to Writing H&P's and SOAP Notes. Dr. Tami Hendriksz, et al.
- True Learn Question Bank