Best Practices for Electronic Clinical Note Writing – Consults, Daily Progress Notes, Sign-off Notes
Fellow Guidelines

1. Fellows must use the standard template(s) for all notes – these are division standards and other providers should be able to see a relatively consistent format to ID notes.

2. Our note templates have been developed such that information considered relevant in an ID consultation or follow-up note is included, together with information required for billing. Do not delete sections/subheadings even if you think they don’t apply to your patient or believe they aren’t clinically relevant for that patient. Even if you believe your note contains all clinically relevant information, omitting other sections or subheadings will likely result in a note that fails to support the appropriate billing level for the care provided. If, for example, the patient does not have any pets at home, state that in the note, rather than deleting the header about pets, so that it is evident that you asked the question.

3. At times you may gather particular items of patient information, such as past medical history or details of the current hospital course, from not just the patient’s family but also other providers’ notes. Rather than simply copying such information from other providers’ notes, be sure to verify all information included in your note with either the patient’s family or other providers, as appropriate. If you do include in your note verified information that was originally obtained from another provider’s note, be sure to indicate the source of the information (e.g., per admission note by Dr. X on date Y).

4. Because we use an electronic system, many more people can easily access and read our notes – nurses, students, outside providers, etc. – than in a paper system. This makes accuracy and completeness especially important.
   a. All notes, particularly initial consults, should have minimal use of abbreviations, especially non-standard abbreviations.
   b. Antimicrobial recommendations should be given precisely in both absolute and weight-based (mg/kg) doses and with the correct dosing interval. If the patient is receiving an adult dose, write the absolute dose in milligrams and interval, and then state “adult dose” so that it is apparent that dosing in mg/kg does not apply.
   c. Proofread to make sure what you are saying makes sense, and check for spelling errors and typos. Note that Powerchart has a spellcheck function.
   d. Remember that your note is a legal document, so make sure everything you write is accurate.
   e. Recommendations should be NUMBERED instead of written in paragraph form or with bullet points/dashes. This will help to minimize errors or overlooked recommendations.

5. Although preliminary notes are not meant to be acted on, they are often read by other providers.
   a. If you are cutting and pasting into a note from a previous day’s note, make sure the information is accurate and appropriate for the current note (i.e. if it was antibiotic day 2/14 yesterday, make sure to update today’s note with the correct count).
   b. Even if you plan to “clean up” a preliminary note later, people can still see the information, so it is not appropriate for a nonsensical note to be in place.

6. A subspecialty initial consult note is a different type of note than a progress note, a resident admission note, etc. It is more formal and comprehensive and often goes to the primary and other providers upon discharge.

7. Sign-off notes should be written on every patient when the ID team and primary team have agreed that ongoing follow-up is no longer needed or at the time of discharge. The sign-off note should include a brief
summary of the key clinical events, diagnostic study results, and final diagnosis and most importantly, the final recommendations from the ID team in a numbered format. Follow guidelines in the document “Outpatient Follow-up of Inpatient Consults,” available on the Clinical Fellowship page of www.ChasingMicrobes.com. Sign-off notes will be used by Elizabeth Nolan and others in clinic to schedule outpatient follow-up visits and understand the final recommendations of the inpatient team. Be as explicit as possible in your recommendations.

a. To make the note easy to find, write it as a consultation note in Powerchart, not an inpatient daily note.

b. State whether ID outpatient follow-up is needed. If follow-up is needed, follow the procedures outlined in the Inpatient to Outpatient Follow-up Guidelines document. Alternatively, state that NO ID follow-up is needed.

c. Use the proper template for OPAT Sign-Off notes for patients being discharged on IV antibiotics.

d. If you are seeing a patient as a one-time consult, state this is clearly at the end of the recommendations for the initial consult. These patients do not need a separate sign-off note.

8. Please feel free to ask the attending physician on your clinical block, Mari, or Tanvi if you have questions about writing clinical notes. Remember that you are evaluated on your note writing during each clinical block by the attending on service with you.