Tips for Notes on Inpatient Family Medicine

1. **Use the templates.** All of them will begin with .ucfm (let us know if you don't have access to these). There is a list on the website.
2. **Put in the time to trim the H&P to that first progress note (day 2).** You can remove most/all of the ddx discussion since things will be somewhat more narrow. Avoid including results in the A/P since those should be above in labs/imaging/micro and anyone who has access to your note can access these details elsewhere. The more excess writing you trim, the more efficient you will be in updating the note each day and keeping it fully updated!!
3. **Remove diagnoses that have resolved.** Ex: Elevated AST that was mild and resolved. Hypokalemia that was replaced and now normal. It is a personal preference on how many to remove since some people will want to keep things to carry into the discharge summary.
4. **Reorder diagnoses as they shift.** Ex: If the patient was initially admitted for pneumonia a week ago and now we are mainly addressing the GI bleed then move pneumonia down on the list and "completed course of antibiotics" is adequate. This will help you keep perspective on what to address on rounds as well.
5. **Add diagnoses that arise.** It is important to keep an updated problem list to make sure you address every abnormal symptom, lab, sign, imaging finding, etc. Ex: New hypoxia, new dyspnea or headache, incidentaloma, pulmonary nodule, renal cyst.
6. **Do not include specific lab values in the assessment and plan.** Anyone who has access to your note has access to the lab section and the templates pull most daily labs into the note. This is one more thing you need to update each day. You can say "improving, stable, worsening" as your assessment for the hemoglobin but the specific value is overkill to add each day.
7. **Use dates instead of "today" or "tomorrow".** Again, these are things you'll have to update every day. Ex: Echo ordered 10/12 instead of echo ordered today.
8. **Do not include specific doses of medications.** There are exceptions if you cannot recall the specific dose (diuretics, insulin) for discussion on rounds and want it in your note. But for the most part, these can be found by anyone looking at your note. Ex: Titrate insulin for improved control or increasing lantus or increasing to medium SSI 10/13.
9. **DO include the specific day of antibiotic.** This helps us make sure we know don't lose track. Ex: Day 3 of 5 antibiotic for community-acquired pneumonia. Exception is if someone is going to be on 6 weeks of antibiotics or a prolonged course. Then it is appropriate to just put the stop date as determined by doing the math or per ID recommendations.