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A Policy Is Born

The policy was customized for CHHC, taking into consideration local adaptation. (See "Sample Policy: Protecting Patient Privacy from Outside Callers" page 66.)

We chose not to use the account number for ambulatory patients as a way of screening callers. Ambulatory patients are not given ID bands and do not have a readily accessible account number to share with select individuals. Members of the privacy workgroup from the ambulatory setting were concerned that it would serve as a barrier. Instead, the workgroup opted for the combination of full legal name and date of birth.

A second issue was related to the scope of involvement of social workers. The social services department was concerned that some patients might not understand the process. This interfered with a legitimate need to verify the condition of the child. With

input from the social work council, the present policy was determined to be acceptable and the role of the social worker would be one of parent advocate to facilitate understanding the process. The privacy task force validated this concern and advised that the need be addressed by the judgment of the patient's nurse, involving the social workers as appropriate.

Next steps for CHHS include finalization of the policy through approval by the center's HIPAA steering committee, policy steering committee, and operations council. Registration and clinical personnel will be educated during upcoming training sessions. ♦

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The Elements of Electronic Note Style

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Has your organization taken note of its electronic note style? Each year, more healthcare organizations adopt electronic health record (EHR) systems and, at the same time, implement a system of electronic note writing.

In many EHR systems, notes can be dictated, entered using note templates, or typed into an empty screen. Note templates contain headings and the provision to import patient information (such as vital signs) into the note automatically when the clinician selects the template for use. While the widespread adoption of electronic notes provides the opportunity to reconsider the purposes of the medical record, a central principle remains—to communicate the author's findings, impression, and treatment plan to others providing care to a patient.

In 1997, we implemented a computerized patient record system at VA Puget Sound Health Care System in Seattle, WA. Afterward, electronic notes became more common, were longer than written ones, and often included text copied from others' notes, frequently without attribution.¹ To help users write better electronic notes, we wrote and circulated a brief document, which was inspired by Strunk and White's *The Elements of Style*. This article summarizes that document and offers helpful tips on how to write effective electronic notes.

Writing Notes Well

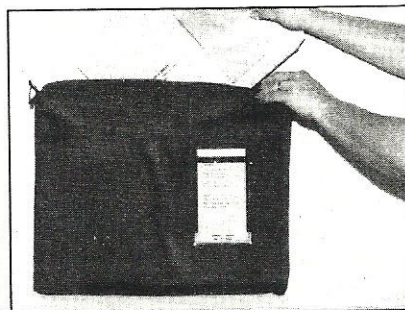
The nature of electronic notes relates, in part, to the techniques and functions available on a computer. When clinicians wrote by hand, they had little inclination to put into each daily note a complete compilation of all laboratory results, medical problems, medications, verbatim reports of imaging tests, and sundry other data. This would have been a laborious task.

Now, with the option to copy and paste, including such data requires lit-

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tle effort. Unfortunately, rather than providing concise summaries of new developments, clinicians are now simply entering the information as though it spoke for itself. Moreover, because it is easy to copy notes without updating the information, the notes are sometimes virtually identical day after day. The following simple rules should help to ensure thoughtful, concise, and readable notes.

1. Omit needless text: Succinct notes are more readable than lengthy discourses. Particularly troublesome are long checklists that are not checked through, which the reader must search for positive or negative findings. If a section of a template doesn't apply to your patient, delete it. Don't remove required sections, however (see rule 8).

2. Make sure the reader knows what you observed in the history and physical and does not confuse it with what you or another observer recorded at a different time: Your note is stamped with a date and time when you sign it. Unless you indicate otherwise, the reader will assume that you observed the findings described in your note shortly before you wrote it. If you incorporate another's history or physical into your note or use your own from another time, the information given may inaccurately reflect the patient's status at the time of your note. Such misleading notes can create clinical, financial, and legal problems for you, your patient, and the institution.

3. Don't copy others' notes: In your written assessment, a clear and intelligent discussion of a patient's problem is a valuable contribution to the patient's care and allows other clinicians to understand your thoughts about a case. You should write this evaluation and plan yourself. Copying others' notes without attribution is plagiarism, a morally and legally indefensible act.

4. Refer to laboratory findings, radiology reports, and other information in the record without copying them verbatim into your note: Readers can look up details elsewhere in the record, if necessary. "Electrolytes normal" or "Lung biopsy pathology report shows

adenocarcinoma" is sufficient for a progress note. The reader can view all the individual electrolyte results or the pathologist's complete report in the appropriate sections of the EHR. Those who read the medical record sent to outside institutions would also have access to those results.

5. Review and sign your notes promptly: In many EHR systems, your note is unavailable for others to view until you sign it. This feature prevents other clinicians from taking action based on a note that you are still writing and may change or delete. Once you have signed it, you can provide further information in an addendum, if necessary.

6. Strive to make your note visually attractive: Proper use of headings, indentation, and other visual guides will make the note more readable and appear more professional. Remember that what you write today will remain in the record with your name attached to it for a very long time. This fact does not mean that you should spend hours embellishing your note, but you should develop habits that improve its appearance.

7. Don't use abbreviations that others may not understand: Don't assume readers know what ESRD (end-stage renal disease), STHB (said to have been), or other abbreviations mean. If you aren't sure, use a spell checker or macro to expand abbreviations.

8. Follow rules that govern the content or structure of a note: Examples of notes with rules are discharge summaries, preoperative anesthesiology notes, initial clinic visits, and nursing admission assessments. The structure of these notes derives from local policy, accreditation, and regulatory organizations such as the Joint Commission and payers. Some rules concern note content and format, including those needed for reimbursement under the HCFA (now the Centers for Medicare & Medicaid Services) Evaluation and Management guidelines of 1997.²

To provide the best possible care, we should develop new note-writing techniques, study and improve them, and train health professional students to use these tools effectively. ♦

Notes

1. Payne, Thomas H. et al. "Implementation of the Computerized Patient Record System and Other Clinical Computing Applications at the VA Puget Sound Health Care System." Proceedings of the Sixth Annual Nicholas E. Davies CPR Recognition Symposium. Bethesda, MD: CPRI-HOST, 2000.

2. Health Care Financing Administration and the American Medical Association. "1997 Documentation Guidelines for Evaluation and Management Services." Baltimore, MD: Health Care Financing Administration, May 1997. Available at www.cms.hhs.gov/medlearn/master1.pdf.

Acknowledgment

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