The Dos and Don’ts of Note Writing in the ICU

Please make sure you DO the following:

Write a note on every patient, every day, including the day they are transferred to the floor or discharged from the hospital. If the team rounded on a patient that day, a note is required.

- If a patient is admitted before midnight, the admission note should be dated for that day in ORCA and they need a separate progress note on the post-call day with all of the required elements.
- If a patient is admitted after midnight, the admission note should be dated for the post-call day and you only need a paragraph-length addendum to the admission note with updates on the daily plan based on discussion during morning rounds.
- Transfer Notes or Discharge Summaries can count as the daily note only if they have the required note elements (ID/CC, ROS, Exam etc.)

Use the Admission or ICU Inpatient templates for all admission notes and daily progress notes.

Include the ID/CC on all admission and daily progress notes and update the chief complaint based on the most active issue for that patient. This is a brief statement (eg. 55 year-old man admitted with pneumonia with new onset of oliguric renal failure). In the ICU, “Primary Concern” is an acceptable substitute for “Chief Complaint.”

Include the Past, Social and Family History and Review of Systems on all admission notes.

- If this information cannot be obtained, check the box indicating that the information cannot be obtained and state a reason why that is so (eg. the patient is intubated or the patient has altered mental status).
- The review of systems on admission notes should include at least 10 systems.
- It is acceptable to write: “Aside from that noted in the HPI, the remainder of the complete review of systems is negative.” Do not, however, write, “A 10-point review of systems was completed and is negative.”

Include a Review of Systems on all daily progress notes.

- If an ROS cannot be obtained, check the box indicating that the information cannot be obtained and state a reason why that is so (eg. the patient is intubated or the patient has altered mental status).
- On daily progress notes, the review of systems should include 2-4 systems.
- It is acceptable to write: “Aside from that noted in the interval events section, the remainder of the review of systems is negative.”

Provide a full description of the previous day’s events/major results under the
section Interval Events. Be sure to comment on which plans from the previous day were completed and which plans remain incomplete (and why that is so).

Add statements about the main radiologic studies and microbiologic results from the previous 24 hours. This should be your summary or the team’s interpretation of the findings and not a simple cutting and pasting of the information from other reports.

Begin your Assessment and Plan with a concise global assessment of why the patient is in the ICU, how they are doing and major issues for that day (eg. “54 year-old man admitted with pneumonia and sepsis who remains hemodynamically unstable requiring pressors and mechanical ventilatory support.”) Your goal should be that anyone reading the chart for the first time starting with your note has a sense of why the patient is in the ICU and how they are doing. This should not rehash data presented earlier in the note, as one of your goals should be to avoid redundancy.

The Assessment / Plan should be organized by problems rather than by systems. Provide specific diagnoses for the patient’s problems (eg. Acute respiratory failure, sepsis, acute renal insufficiency). If a precise diagnosis is not known for a particular problem, you can list the problem itself and a differential diagnosis (eg. “Problem 1: Hypoxemia. Differential diagnosis includes pneumonia, PE, ARDS” or “Problem 1: Hypotension: likely due to sepsis but could be due to GI bleed or volume depletion”).

Document all consultation requests for that day and the reason for the consultation.

Please make sure you DON’T do the following

Do NOT copy and paste your Physical Exam and Assessment and Plan from prior notes into your current note without making sufficient changes. While it is tempting from a time and efficiency standpoint to simply copy your previous notes into the current one, you must be careful to make significant changes to reflect the fact that you saw the patient and did original work on the patient that day. Failure to do so is considered unprofessional.

Do NOT copy and paste full radiology reports and microbiology data into your progress notes. Instead, provide a concise, one-two line summary of these results.

Do NOT include problems in your Assessment and Plan if they have not been an active issue for more than a few days. (eg. if they had atrial fibrillation that resolved on hospital day 2, you do not need to comment on it on hospital day 10). Resolved problems can be added to the patient’s problem list.

Do NOT simply list “no overnight events” in the Interval Events section of the daily progress note. There should be at least a few statements summarizing what transpired during the previous 24-hour period. There are always events for ICU patients, some good, some bad.