Writing an Effective Daily Progress Note

We write progress notes to communicate with colleagues and the health care team the essentials of our patients' medical issues to help everyone provide the best care to the patient. It is not a billing document. It also is not an assignment to show off all your medical knowledge in order to get a good grade. Progress note rarely should exceed a page in length as no one will really read much beyond that anyway. The following are guidelines for writing an effective progress note in an inpatient setting using the SOAP format.

Always clearly label your note as "Medical Student Progress Note" or "MS3 Note"

S- This is where you record the information the patient tells you about how they did overnight. While it is important to allow the patient time to tell you all their concerns, you only document those things that are relevant to the acute medical problems.

For example level of pain control, bowel/bladder issues, breathing problems/improvements, new medical complaints. This is not where you record that the patient didn't like her meal or "they" were slow answering his call button, the TV didn't work, etc. It is also not where you record lab findings or study results that returned overnight.

Hint: students often include too much detail and extraneous information in this section

O- This is the focused physical exam findings and lab, radiology, and other study results that are new since the last note. Always start with the vitals including daily weights and O2 sats. We typically include fluid balance, drain outputs, ventilator settings, and other monitor readings here as well. Chemsticks can be included here or under labs. Give a brief comment on general appearance specifically addressing whether they are looking acutely ill. Document the parts of the physical exam that are relevant to the patient's active medical problem(s). Regardless of the medical problem, some doctors like the heart, lungs, and abdomen examined on every patient. You won't be wrong to do this but it is not always necessary. By convention, blood tests are recorded after physical exam, followed by x-rays, ECGs, and other study results.

Hint: Students often do not emphasize the pertinent findings including the changes overnight. Cutting and pasting complete reports from studies is too much- the bottom line goes in the progress note as the full report is already on line.

A- This is where you state the working diagnosis and comment on whether it is improving, worsening, or the same. You do not need to rehash all your rationale for making this diagnosis if it was previously documented. If the working diagnosis is uncertain, you still commit to the most likely diagnosis and then list any other diagnoses you are actively working up or empirically treating.

Hint: A note without an assessment (working diagnosis NOT body system or symptom) is a "SOP" note, and no one wants to be a sop. The assessment is what separates you from a mere reporter of data.

P- This is where you list the plan, tests, and/or therapies. If it is not obvious why you are ordering something or initiating treatment you should provide rationale. (You would not repeat that comment in subsequent notes.)

Hint: Students frequently do not put enough specific details into the plan (e.g. don't write "antibiotics", write "ceftriaxone 1 gram IV every 24 hours"). Write the amount of detail you would need in order to write the order.

A/P- This combined format is frequently used when patients have multiple active problems. You still follow the instructions for A and P above but number each diagnosis separately. It is very important to prioritize the diagnoses in this scenario so someone reading your note will find the most acute problems addressed first.

Sometimes in complicated patients it is helpful to give an overview sentence or "bullet" that notes the key working diagnoses and how the patient is responding upfront so someone can get the big picture quickly. E.g. " 57 yo woman with LLL pneumonia likely pneumococcus with improved O2 sats on day 2 levofloxacin, uncontrolled type 2 DM with improved glucose control, and resolving hypovolemic hyponatremia"

The advantage to a summary statement like this is that you know your patient best and are essentially prioritizing the issues for your colleagues who may be covering for you and they will appreciate this. The ability to succinctly summarize a patient's issues and hospital course is also a useful skill that is worth practicing any chance you get because this is exactly the skill you use when calling consults and handing off patients.

Hint: Students frequently keep the same amount of detailed explanations in the A/P that they gave on day 1 on every subsequent hospital day which leads to the 2-3 page progress note that no one likes to write or read. You only need to document your rationale once and you don't need to keep discussing diagnoses that are no longer active (e.g. hypovolemic hyponatremia that was treated and has resolved)