One Good Note

Recently, one of our staff cardiologists thanked me for my note on a patient who was transferred from the coronary care unit, where I practise, to the cardiology ward, where she was on service. What impressed me even more than her actually knowing my name (we don't usually work together) was her acknowledgement of my documentation. Her follow-up comment was that my note was very legible—I had to infer that the content of the note was just as helpful as its legibility. This was not the first time I'd received such feedback, and it's the same theme every time: the note was a good one, with primary emphasis on its legibility.

Because I work in a critical care area and as such am often involved when patients are transferred to other units, I try to write at least "one good note" for each of my patients, typing the note on a computer, printing it out, and then signing it before adding it to the chart (my institution still uses paper-based charts). I use a blank word-processing file and employ a modified DAP (data, assessment, plan) format that includes a brief history, medication reconciliation, and, most important, a treatment plan. The feedback I've received regarding my notes has led me to contemplate the nature of documentation in pharmacy practice and health care in general. Why is it that the single most important perceived advantage of my notes is their legibility? How can something so simple be so valuable?

We all know the stigma of physicians' handwriting. Despite our reputation for being able to decipher poor handwriting, as pharmacists I don't think this is something we should be proud of. Why do we allow prescription illegibility to continue? We have expensive automated drug delivery systems—why can't we have easily legible (typed) notes? Compare the ease of reading a typed note with my daily frustration and struggle to decipher numerous scribbled notes in my efforts to provide collaborative care to my patients. Reading one of these notes aloud would sound something like this: "Fifty-year-old male admitted for something something chest pain … wife called … someone … on exam, patient appeared … something … scribble scribble … skip to the bottom … diagnosis: inferior STEMI." I think patients would be appalled to find out how often a mistake in their care could be or is made because of bad handwriting. We often compare health care to the aviation industry, so imagine the public's outrage if a plane landed at the wrong airport because the pilot couldn't read the navigator's handwriting—there would be a revolution!

Now, how does one write a good note? I don't believe that proper documentation is taught well to health care providers, including pharmacists. In addition, there's a paucity of evidence to support or refute various types of documentation in health care. However, I personally believe that typed notes have many advantages. They can be used to organize your thoughts for patients with complicated conditions and are easily editable (for example trainees are typically not forced to rewrite drafts of their chart notes). However, I acknowledge there are pitfalls to this approach. For example, in a poignant narrative, Dr Robert Hirschtick described notes typed by medical residents as "long, thorough, and unreadable".[1] Here are 3 tips that I try to follow in my practice to avoid these problems.

First, keep it brief. A note should never exceed 1 printed page. Don't let the temptation of a blank template and your Facebook-honed typing skills get the better of you. As Hirschtick suggests, take advantage of today's concise, "140-character NNT (number needed to tweet)" communication style.

Second, beware of the standardized, fill-in-the-blank template. It can be just as dangerous as a poorly written note. Such passport application–like notes may seem appealing, but they often lack meaningful interpretation and assessment, and the redundancy caused by cutting-and-pasting from previous notes is both easy and ineffective.

Third, document more in the patient record and less on monitoring forms. I realize it's time-consuming to document in the chart; however, I would argue it's a worthwhile investment. Contrast this expenditure of time with how much time pharmacists spend documenting on some type of patient monitoring form that no one other than themselves (or occasionally another pharmacist) will ever access. If you're going to spend the time performing a detailed workup, why not share that information with your colleagues in the form of a concise and clearly written chart note? Most of us in the millennial generation can type faster than we can write anyway, and legibility in this format is not an issue.

I believe that the legibility of patient information, especially that intended for other health care providers, is an important patient safety issue. If you take the time to create one good note for each of your patients, you may be surprised at the positive feedback you receive.

Reference

1. Hirschtick RE. John Lennon's elbow. *JAMA.* 2012;308(5):463-4.

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