DOCUMENTATION FEEDBACK TOOL FOR COACHING

Date of observation: ________________

Service: ________________

Documentation reviewed:

☐ H&P      ☐ Progress note      ☐ Discharge summary      ☐ Other ____

HISTORY

1. History of Present Illness: chronology, completeness, and organization. HPI should generally begin with the first real change in health status related to the chief complaint and conclude at the time the note writer assumes patient care.

☐ organized with clear sequence of events
☐ contains sufficient detail
☐ hypothesis (differential diagnosis) driven, clear and comprehensive without extraneous information.
☐ includes PHM, FH, SH elements that help distinguish among diagnoses under consideration

Comments on HPI __________________________________________________________________________

2. Past Medical, Family, Social History, Review of Systems, Allergies

☐ includes major elements in each category
☐ includes relevant history (ie HEADSS for adolescents, seasonal influenza vaccine, birth history for infants, etc)
☐ includes detailed reactions to any allergies, as applicable

Comments _______________________________________________________________________________

3. Progress note: Interval history

☐ describes events over last 24h
☐ includes changes in patient’s condition
☐ patient/parent report of status

3. Physical Exam

☐ Accurately describes findings (positive or negative) in at least 8 organ systems/body areas
☐ accurate terminology
☐ hypothesis (differential diagnosis) driven exam. Documents subtle findings or additional maneuvers that help distinguish among diagnoses under consideration

Comments _______________________________________________________________________________

4. Diagnostic Studies

☐ includes pertinent labs only (not a detailed list generated by the EMR with extraneous information)
☐ include trends/comparisons with past findings

Comments: ______________________________________________________________________________

Developed by Marta King, MD, MEd
5. **Assessment/Problem representation**

- [ ] big picture synthesis of critical history, physical exam and diagnostic study elements
- [ ] appropriate use of semantic qualifiers (acute/chronic, mild/severe, localized/diffuse, right/left, bilious/nonbilious, etc)

Comments: _____________________________________________________________

6. **Differential Diagnosis**

- [ ] lists more than one potential diagnosis
- [ ] prioritizes differential diagnosis based on diagnostic reasoning supported by relevant H&P elements
- [ ] includes a prioritized DDx for secondary problems, if pertinent

Comments: _____________________________________________________________

7. **Problem List**:  

- [ ] identifies and prioritizes primary problems
- [ ] as applicable, identifies and prioritizes secondary problems (ie secondhand smoke exposure, underimmunized status, etc)

Comments: _____________________________________________________________

8. **Plan**: diagnostic and therapeutic

- [ ] Addresses all important issues and includes decision making rationale
- [ ] Includes patient/family education and discharge planning when appropriate
- [ ] Includes patient/family preferences when appropriate
- [ ] Refers to literature/practice guidelines when appropriate
- [ ] discusses code status as applicable

**Overall level of detail:**

- [ ] Effective
- [ ] more detail needed
- [ ] excessive detail provided
- [ ] appropriate length for complexity of patient

Comments: _____________________________________________________________

**Inaccuracies:**

- [ ] copy/forward errors
- [ ] unclear abbreviations used

Comments: _____________________________________________________________

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