

Study shows doctors record better notes after using best-practices program

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The quality and efficiency of notes doctors took about their patients improved when they received education and guidelines that emphasized best practices. In a study led by UCLA researchers, physicians were instructed to document only what was relevant for that day and were discouraged from using some common tools that are intended to make note-taking more efficient. During the study period, physicians produced shorter, higher quality notes and completed the notes earlier in the day. By limiting the efficiency tools, note writing actually became more efficient.

The widespread adoption of [electronic health records](#) is helping to modernize [health care delivery](#). However, the growth of electronic health records posed some challenges for accurate and concise documentation of physician notes. Experts have described several problems that are occurring in physician notes. One is inaccurate information that leads to errors. Another is inconsistent or outdated information that doesn't get corrected in the patient's record—a practice referred to as "copying-forward." While another is the phenomenon of "note bloat" in which physician notes are overly long and contain nonessential information. The UCLA researchers explored whether an education program used in combination with a template used to guide doctors through the note-taking process can improve the quality, length and timeliness of [physician](#) notes.

The quality improvement study, led by Dr. Neveen El-Farra and Dr. Daniel Kahn of the department of medicine at the David Geffen School of Medicine at UCLA, was conducted at four academic internal medicine residency programs. The residents participated in brief educational conferences and received an electronic progress note template that incorporated a set of best practice guidelines. The template was designed to minimize the use of common efficiency tools, such as the auto-population of notes and to encourage the physicians to enter relevant information in specific

fields. The template included an inpatient checklist for documenting patient concerns, quality measures, discharge planning and other data.

The researchers found that by prompting the doctors to document only what is relevant for that day and by limiting efficiency tools such as copying-forward and autofill, the progress notes were significantly improved for quality, were shorter in length and were completed more quickly. Future research, the authors wrote, could expand on the results of the study by introducing similar progress note interventions at other institutions and nonacademic environments.

The study is published today in the *Journal of Hospital Medicine*.

Provided by University of California, Los Angeles

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