Writing Casualty Notes

- Clinical documentation is essential for communication between health care professional to ensure safe and effective care. It also forms the basis of evidence of care to be used for insurance purposes, legal analysis, quality improvement and research.
- Good notes need to be clear, concise and complete, but without duplicating information. They should be completed as soon as possible after an episode of care and after every contact with the patient.
- Do not copy and paste
- Interns should consult for each case. Record who you consulted with and what was communicated

SUBJECTIVE:	
CC	**** year old female/male patient with PMH of *** is here today for ****
HPI	• Include location, quality, severity, duration, timing, context, modifying factors, associated signs and symptoms. • Make sure to document presence/absence of RED FLAGS. • If multiple presenting problems then make a problem list and tackle each issue separately.
ROS	Include pertinent ones from relevant organ systems; don't forget **mental health**
Meds	Include **generic** name of medication instead of brand, as well as doses and when last taken. Don't forget contraception!
Allergies	Medication and reaction
PMSH	• Hx of chronic illnesses • Hx of surgery • Any admissions • Hx of transfusions, HIV tests/status • Obstetric history and **LMP**
FSH	• Work, home, social support structures • NHIF or other insurance • FH of cardiovascular dx/cancer/autoimmune as pertinent • Alcohol, tobacco, drug use • **Spiritual history**

OBJECTIVE:

(Document what you examined! "*Exam benign*" or "*normal/nonfocal*" is not adequate)

- **Appearance/general**
- **Vital signs** (complete set. Any abnormal vitals make sure to comment in your assessment)
- **Focused physical exam** as indicated by history
- **Investigations:** Any from elsewhere. Document to show you have reviewed.

ASSESSMENT AND PLAN:

Impression – what do you think is going on? (not just a summary)
Include your **differential diagnosis**: *"Differential includes ……. Most likely diagnosis is ……."*

- If addressing **multiple problems** can put assessment and plan for each problem, e.g.:

  # Chest pain – Differential ACS, HTNsive emergency, PNA, chostochondritis, GERD. Suspect ACS v/s hypertensive emergency.
  - *STAT ECG and troponins*
  - *ASA and atorvastatin*
  - *Pending ECG for further plans*

  # Known DM/HTN – BP currently high at 190/100. RBS currently stable at 8.
  - *Consider labetalol/nifedipine for cautious BP lowering pending ECG*
  - *Continue BP monitoring Q 30mins*
  - *UECs STAT*
- **Disposition** if immediately apparent.
- Be sure to include **follow-up plan and safety netting** if immediate plan includes discharge.
- If you have consulted with someone more senior, make sure you document who this was and what was communicated

REASSESSMENT NOTE

(To be written after **EVERY** contact with the patient!)

Subjective:

- How is patient faring now, any change in complaints with time or management so far?

Objective:

- Updated VS and exam
- Results of tests that you ordered

Assessment and Plan:

- Discussion of final diagnosis and continued management after investigations
- Disposition
- Follow-up plan and safety netting if they are being discharged
- If you have consulted with someone more senior, make sure you document who this was and what was communicated