General things to consider:

- *The chart is a legal document & at some point in your career you will go to court*
- *Don't forget to date and time stamp everything*
- *If its not written down you didn't do it*
- *Write legibly. Sign AND print name. Include rank and pager number. They will find you anyways so make it easy*
- *Stay classy UBC. Be professional and cordial in all notes and dictations*

CONSULTS:

- *Be systematic and efficient. Don't cut corners.*
- *Answer the specific question being asked. If they are waiting on your opinion, take a pager number and follow up. If plans change then you need to notify the service*
- *Review w staff early and always note who you reviewed with (protect yourself)*
- *Write the dictation number on the consult (this proves you dictated & allows other services to listen before it is transcribed)*

Consulting Service:	
Consulting Attending:	
ID:	
Reason for Referral:	*PMHx:*
HPI:	*PSHX:*
Subjective complaints:	*Meds: (anticoagulants?)*
Exam findings:	*Allergies: (include Rxn)*
Investigations (Imaging and labs):	*Soc: (smoke?)*
Dx (+/-DDx):	*Draw picture PRN*
Impression (one line summary):	*Reviewed w Dr. Soandso*
Plan:	*Sign, PRINT NAME, Rank, Pager #*

PRE OP: (remember ABCDE²IOU)

- **A - Admit** (service and surgeon, VGH Admitting 62238)
- **B - Book OR** (VGH OR front desk 66310)
- **C - Consent** (Discuss risks, patient signature, get phone number if chair patient)
- **D - Drugs** (Allergy sheet, pharmanet)
- **E - Extremity** (Pre-op marking, Splint, Dressing)
- **E - Explain** (give patient instructions and explain what will happen)
- **I - Involve appropriate services** (Anaesthesia / Cardiology etc need to see pre-op?)
- **O - Orders** (pain Rx, Pre-op Abx)
- **U - Update service list**

POST OP NOTE: (remember PPP SAFE DISC² from surgical recall)

- **P - Pre-op Dx** (what we thought it was before the OR)
- **P - Post-op Dx** (what we thought it was after the OR, often the same as pre-op)
- **P - Procedure** (Describe what was done)
- **S - Surgeons** (Including assistants)
- **A - Anaesthesia** (Anesthetist and type, e.g., general, local, regional block)
- **F - Fluids** (Crystalloid, Colloid, Blood etc. and how much – ask anaesthetist)
- **E - Estimated Blood Loss** (ask anaesthetist)
- **D - Drains** (number, location, and type – drawings are helpful)
- **I - Intra-operative findings** (what would you want to know if you weren't there? Eg. Microsurgery → which vessels?)
- **S - Specimens** (how many, what they were, and if they were sent to Pathology)
- **C - Complications** (if there were any note them and what was done about it)
- **C - Condition** (How the patient was at the end of the case, where they were going, and the plan moving forward. e.g.: "Stable, extubated,to Post Anesthesia Recovery, Plan for discharge in the morning")
- *For extra style points draw a picture*

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Acknowledgements to Drs. Sara Guerra, Sheena Sikora, and Morgan Evans.

POST OP ORDERS: (remember A-D-DAVI³D³)

- **A - Admit to**: (Service and Surgeon. e.g. admit to Dr. Soandso, Plastic Surgery BPTU)
- **D - Diagnosis** (what procedure they just had)
- **D - Diet** (Consider health and physical status e.g.: NPO, CF, FF, DAT, Cardiac diet, Diabetic diet, dental soft, thickened fluids etc. Dietician or SLP swallowing assessment?)
- **A - Activity** (Wt bearing? ROM restrictions? When to move affected area? Limb elevation? Incentive spirometry? Physio to see/mobilize, falls risk?)
- **V - Vitals** (Need monitoring? What to check and how often? E.g. Ins/outs: drains and catheters, O2 Sats, flap checks, NVS. Give criteria – when do you want to be called?)
- **I - IV** (Replacement (ascites = albumin 1:1, Gastric residuals = D5½NSwKCl 1:1) or maintenance (4:2:1 rule, DM NPO need dextrose) Which fluid and at what rate?)
- **I - Ins & Outs** (If you want fluid status to be monitored, e.g Urine, GI)
- **I - Investigations** (blood work – u order u check, freq? imaging – include indication)
- **D - Drugs** (for drugs cover the 8 P's)
  - **P - Pain** - (Tylenol, T3's, Morphine, Dilauded are most common, perioperative pain service will follow most inpatients)
  - **P - Puke** (Prevention of PONV, Gravol, Maxeran, Ondansetron etc)
  - **P - Poop** ("The hand that prescribes the narcotic prescribes the laxative". Vasc Sx bowel protocol is least aggressive)
  - **P - PE** (Does this patient need DVT prophylaxis? Calf compressors, Heparin etc)
  - **P - Psych** (sleep, sedation for anxiety, antipsychotics PRN, CIWA for withdrawal)
  - **P - Prevent Infection** (Does this patient need antibiotics?)
  - **P - Previous medications** (What meds were they on at home? Fill out the MAR, DM Insulin and sliding scale)
  - **P - Procedure specific** (some operations require special Rx. E.g. ASA, dextran following free flaps)
- **D - Drains** (When to remove? Day surgery patients may require a home care referral)
- **D - Dressings** (What type of dressing and how often to change it?)

PROGRESS NOTES: (Remember I-D-SOAP)

- **ID (**eg 41y/oF healthy ped struck from Victoria),
- **Dx (**eg PAD2/POD2 IM nail R femur, POD1 Gastroc rotation flap RLE)
- **S -** What the patient **says** (pain control, ambulation, eating/drinking, bowels/voiding, related to Dz or Sx eg vision, sensation etc.)
- **O -** What you **see** (Vitals (trends), focused exam, Ix (labs, cultures & imaging), Drugs (see MAR – Pain, Abx), Drains (output), Dressings (LOOK under the dressing), LOOK at all lines
- **A -** What you **think** (Eg. Stable, improving/deteriorating etc**.** New or changed dx?)
- **P -** What is the **plan** (both short term(e.g. advance diet, mobilize) and long (e.g., discharge home tomorrow, f/u in 2 weeks)
- *Systematic/organized = combine A/P into a list of issues w plan for each (ICU style)*
- *Talk to the nurse directly about issues (give a heads up if dressings down)*
- *Rationale for each new order should be explained in your A/P*

DISCHARGE / TRANSFER NOTES:

- *Start discharge planning on day 1 (involve the ward)*
- *Patient cant go home until medically/surgically cleared (i.e. eating, pain controlled, ADLs, PT/OT issues, suture/staple removal, homecare for drains/dressings, Rx given, F/u arranged)*
- *Add surgeries and F/U appts to discharge form as you go. Not mandatory HOWEVER this is given to patient at discharge AND you can use this as a template for your D/C dictation.*
- *Tee up scripts/paperwork early (don't dump on your friends, everything ready night before, don't leave discharges for the weekend)*
- *For transfers be thorough, include all information that would be on the discharge form and clearly indicate the plan. Write all transfer orders. (Imagine you are the one who will be receiving this patient, what would you want?)*

DICATIONS:

Dictating (VGH and UBC): Call 1-855-666-3240	Dictating (SPH and MSJ): Call 68707 or 604-806-8707	Dictating (BCCH): Call 6677 or 604-875-2000
Facility: 115 VGH 114 UBCH 97 GFS 96 GPC 105 Richmond 6 Lions Gate	Facility: 11 Holy Family Hospital 12 St. Paul's Hospital 13 Mt. St. Joseph's Hospital 14 Brock Fahrni Pavillion 15 Langara Residential Home 16 Youville Residential Home	Type: 301 History & Physical 302 Consultation (Standard Format) 304 Consultation (Letter Format) 306 Progress Note 313 Letter (Non-Consult) 317 Operative Report 318 Discharge Summary 322 Hereditary/Genetic 324 Clinic Note 337 Delivery Note 338 Rounds Note 342 Assessment 343 Consultation 344 Database 345 Follow-up 346 Progress Note 347 Planning Note 378 Addendum 380 Joint Report
Type: 101 History and Physical 102 Transfer 103 Progress 104 Consultation 105 Anesthetic Consult 106 Delivery 107 Discharge 108 Operative Report 109 Treatment note 111 Outpatient clinic 112 Televisit 114 Diagnostic report 116 EEG 119 Heart Cath 199 Standard text	Type: 05 Transfer Note 10 Outpatient Clinic Note 11 Lipid Clinic 12 Prevention Clinic 14 Heart Cath/Angioplasty 15 Diabetic Day Care 16 EMG Outpatient 19 ECT 25 Geriatric Day Hospital 30 Inpatient Consultation 32 Outpatient Consultation 35 Inpatient History and Phsyical 55 Operative Report 70 Discharge Summary	Begin 2 Pause 2 Resume 2 Rewind 3 Fast forward 4 Skip to end 44 Complete 5 Priority 6 Disconnect 9
Hold 1 Dictate 2 Pause 2 Rewind 3 Fast forward 4 Skip to end 44 Exit 5 Prioritize 6 Complete 8 Demographics 9 Job number #	Begin 2 Pause 2 Resume 2 Rewind 3 Rewind to beginning #3 Fast forward 4 Disconnect 5 Priority 6 Save/End 8 Cancel #0	

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Acknowledgements to Drs. Sara Guerra, Sheena Sikora, and Morgan Evans.

Common preamble: "*This is Dr. Evans (E-V-A-N-S), PGY3 plastic surgery resident, dictating an* ***Operative report/Consult/Discharge summary*** *on behalf of Dr. Bush (B-U-S-H) plastic surgery. Date of dictation: August 14th, 2014. Dictation on patient Mr. John Smith (S-M-I-T-H).* Pt. DOB, Pt. MRN", CC: Primary, Family Doc, Consultants.
Thank you, dictation begins now.

OR REPORT	**CONSULT**	**DISCHARGE**
Procedure Date of procedure Pre-op Dx Post-Op Dx Surgeon Assist Anesthesia (Name and method) EBL Complications Tourniquet time Clinical Preamble... ("Pt *is a 44 yo M who presented to VGH for operative management of skin burn"*) Brought to the OR. Time out Anesthesia and airway (how) Position Tourniquet was placed... Prep and Drape in the normal fashion creating an operative field that involved the..." Local anesthetic Incisions Dissection and method Findings (Important) Procedure (Excised, incised... what was done) Wash out? I&D? Closure Dressings Post-op (Transferred to post-op stretcher, anesthetic reversed, taken to PACU...) Complications (What and why) EBL Tourniquet time Additional notes (Plan for f/u, Plan for drains, plan for repeat OR if necessary) Thank you, END DICTATION	CC:("*Mr. Smith is 56 year old, right-hand-dominant accountant who injured his left little finger yesterday while playing soccer"*) HPI: PMHx: PSHx: Meds and Supplements: Allergies: Social Hx: (smoking, EtOH, drugs, occupation, avocation, family status) FamHx (if relevant): Vitals: General status Heart and Lungs: Focused Physical examination: Investigations: Assessment/Summary: Plan: ("*This plan was discussed with the plastic surgeon on call, Dr. Bush (B-U-S-H), as well as the senior resident on call, Dr. Saunders (S-A-U-N-D-E-R-S)"*) Thank you, END DICTATION	Date of admission Date of discharge Most responsible Dx Pre-admit co-morbidities Post-admit co-morbidities Secondary Dx Treatment/Course in hospital Code status Operative interventions Other interventions Name and service of relevant consultants Allergies Medications on discharge Follow-up appointments, tests, issues Discharge disposition Thank you, END DICTATION