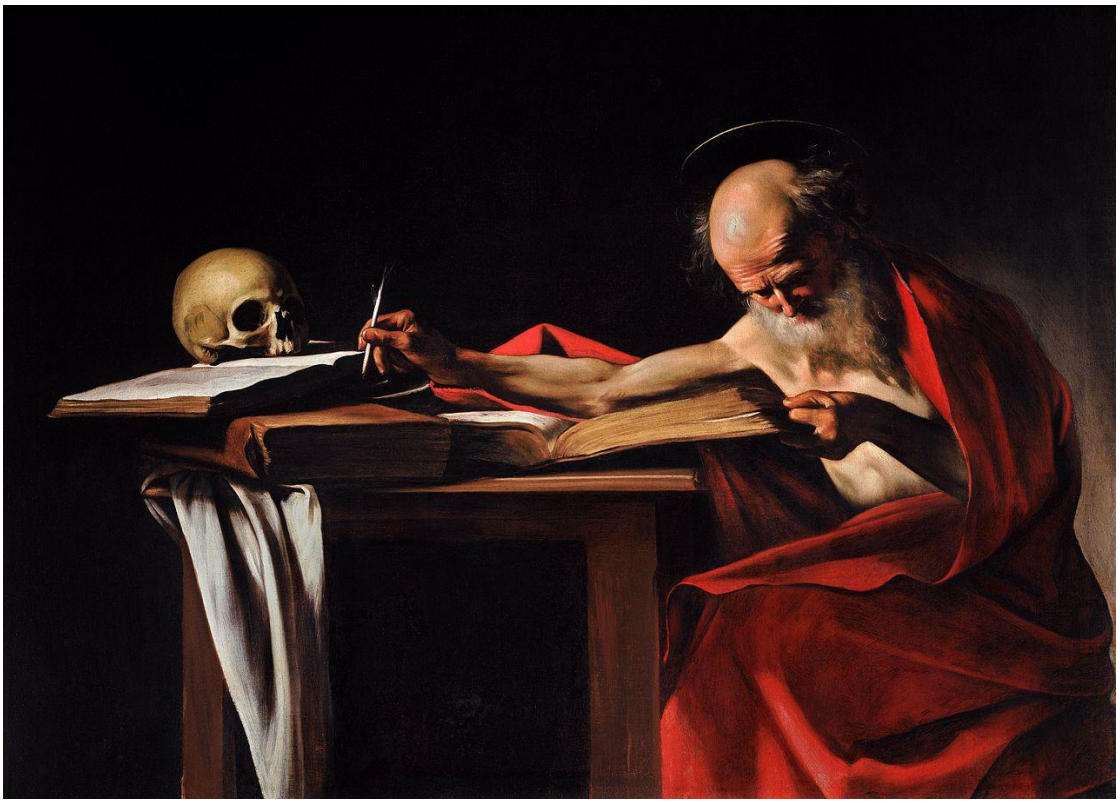


Tips for Efficient Charting

So, I decided to tackle this as a post, not because I feel particularly good at it, but rather BECAUSE I have struggled so much with it. I was probably one of the slowest at charting the first half of second year, having to stay long hours after a shift or coming in on days off to finish notes. It sucked, so I made a conscious effort to come up with some tricks to improve efficiency. It eventually paid off, and now I can pretty comfortably finish notes for 25+ patient shifts before leaving for the day.

Some of it is definitely due to expanded scribe coverage and the availability of interns/students for leg work and procedures. But I do think I have some concrete tricks and tips to help with efficiency. This is likely old news to PGY-3's, PGY-2's may find a few tricks that help bolster them (though as a whole you guys are doing excellent, fwiw). PGY-1's are likely not having too much trouble with notes yet because volume is a bit lower, but establishing good habits will help you hit the ground running at the beginning of your second year.

Work Flow Issues

Avoid Task Switching When Possible

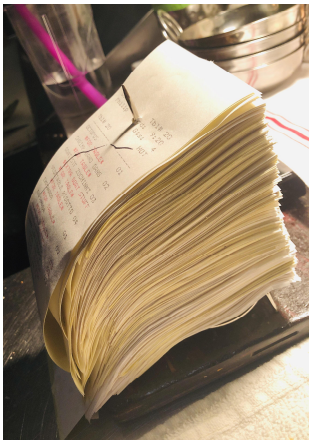
People frequently reference the “squirrel” nature of ED, and it’s a point well taken, HOWEVER frequent task-switching has it’s problems. It’s a cognitive drain, leads to mistakes, and overall decreases efficiency throughout your shift. It’s important to learn how to not get your concentration knocked off of what you are doing by an interruption when it’s not an emergency. If a nurse asks you to put in an order, for instance, how much time and energy does it take to back out of your note, into another patient, put the order in, and then get yourself back where you were? It’s much more efficient overall to just make a quick note, and get to it 60 seconds later after you finish what you are in the middle of. I like to keep a sheet of paper right by my keyboard to jot down interrupting to-do items.

Don’t Load Up
(aka “What’s the best way to eat an elephant?”)

This one took me a while to get because I am hard-headed. Let’s say you come onto shift, or out of Room 9, and there are 6 patients to pick up. You want to be a hard-ass worker and nothing will beat you down, so you sign up for all of them at once, right? It will be more efficient to make one big trip around the loop and see them all at once, right? Wrong!

When you try to do that, you will inevitably get knocked of track by one who is either really sick or really complicated, or maybe another Room9 will come in, or you will want to put in some time sensitive orders to start cooking, or WHATEVER. When that inevitably happens, all of the other patient you picked up will now sit with no forward momentum while you deal with the emergency. You can see the same 6 patient *faster*, by only signing up for the first 2, seeing them, dropping orders, starting your note, and *then* grabbing 2 more, then 2 more, and so on.

This small bite flow will allow you to quickly see those six, but also it works better for nursing, *and* it leads to more even patient distribution. If you get tied up with a few sick ones, the remainder will still be available for your coworker or NP if they have a lull. Trust me, it took like 2 months of Price banging me over the head to finally see this, but it when it sank in, and I realized how true it is.



Finish Your Note at Discharge

You know how they recommend to take boards during your first year out, and not postpone them? You will never be more prepared that right at the end of your training. Similarly, writing a note will be orders of magnitude easier while you are actively discharging than later. All of the important details are right on the tip of your tongue. As the hours pass, details are hazier, you will have to refresh your memory by rechecking labs and imaging, and retrace your decision making for documentation.

There will be pressure to get the discharge in quickly, so it can be tempting to just filling out the Impressions section and click the d/c button. But that will ultimately snowballs 2-3 minutes of work now, into 10-15 minutes of work

later. Multiply that by 10-15 patients, and you have just bought yourself 2-3 hours charting in the back. When you force yourself to do it in the ED, you realize much quicker it is when the details are fresh.

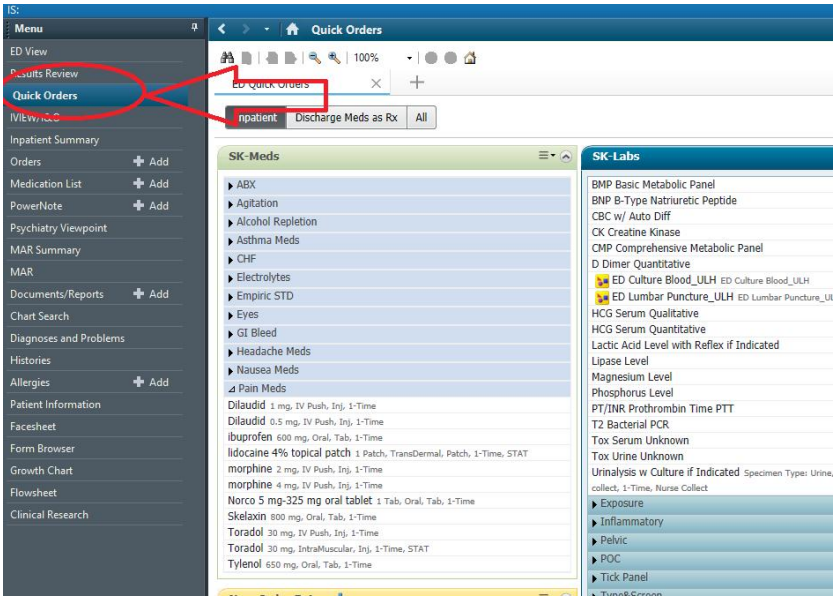
Discharge First

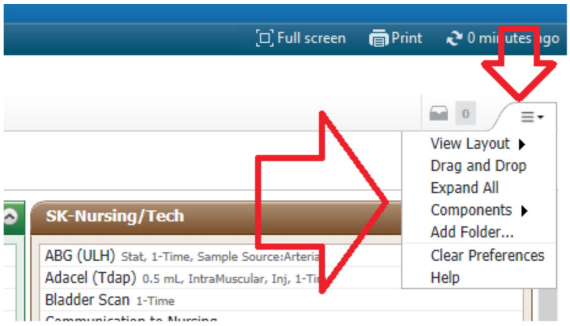
It's easy to struggle with this one, because it can be counter-intuitive to your ED instincts. Try to discharge your patients that are ready to go prior to picking up fresh ones. For instance, you have to discharge those 3 patients, but there are 3 more sick people coming in, they're not actively dying but their triage note is moderately concerning, so the priority is to see them prior to discharging healthy patients, right?!!? Wrong.
If they are in the Main ED, they can very likely wait 5 minutes for you to put in a discharge. It helps to think: if they truly required immediate attention, THEY WOULD BE IN ROOM 9. Alternatively, if you concentrate on getting your discharges in in a timely fashion, it leads to: a) decompression of the overall ED, meaning less stressed nurses, meaning overall everything gets done quicker b) less task switching for you, since those patients are gone they stop bugging nurses/you for meds and updates, c) less overall cognitive burden, since once they are off your list and note done, they are GONE from your mind, and it's easier to focus on the new ones.

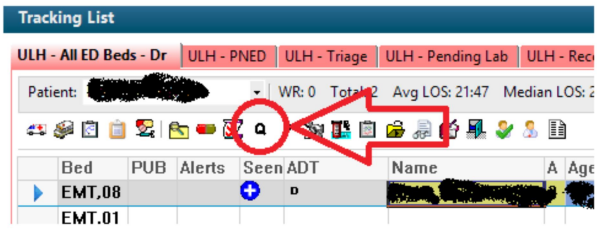
Using Tools Effectively

Cerner: Quick Order Entry

Entering orders is usually one of the strongest nonproductive time sinks early on, especially in this EMR. I remember spending a frustrating amount of time looking for the right esoterically named US order, or entering the correct dosages and formulations for potassium repletion. My suggestion, and something that really helped me build higher patient volume, is to maximize your use of not just favorites, but also the QuickOrders tab. For those who haven't experimented with it, the QuickOrder tab is just a tab-style layout version of your favorites folders. You can organize all of your favorite folders and subfolders, adding them in as expandable selections. You can then drag-and-drop them into the order you want, and then continually update them on the fly. You can start with basic stuff, like all of your commonly ordered pain meds in one folder, or common imaging, and then expand it as you go.

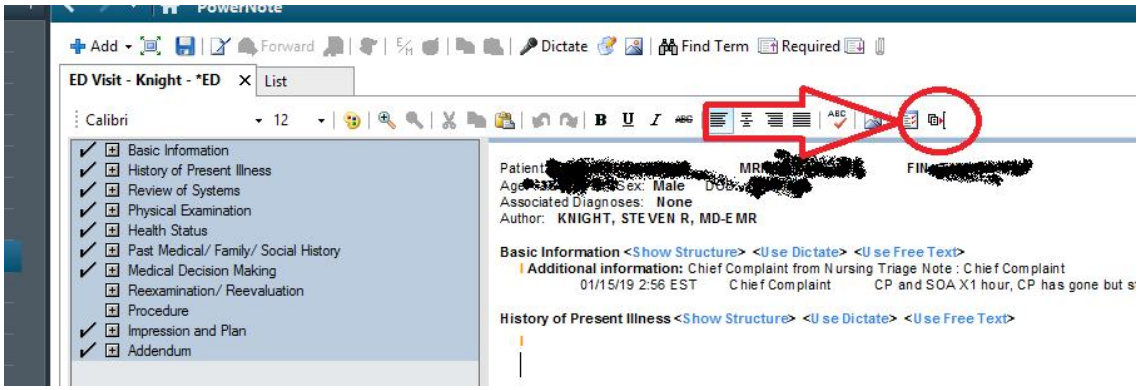


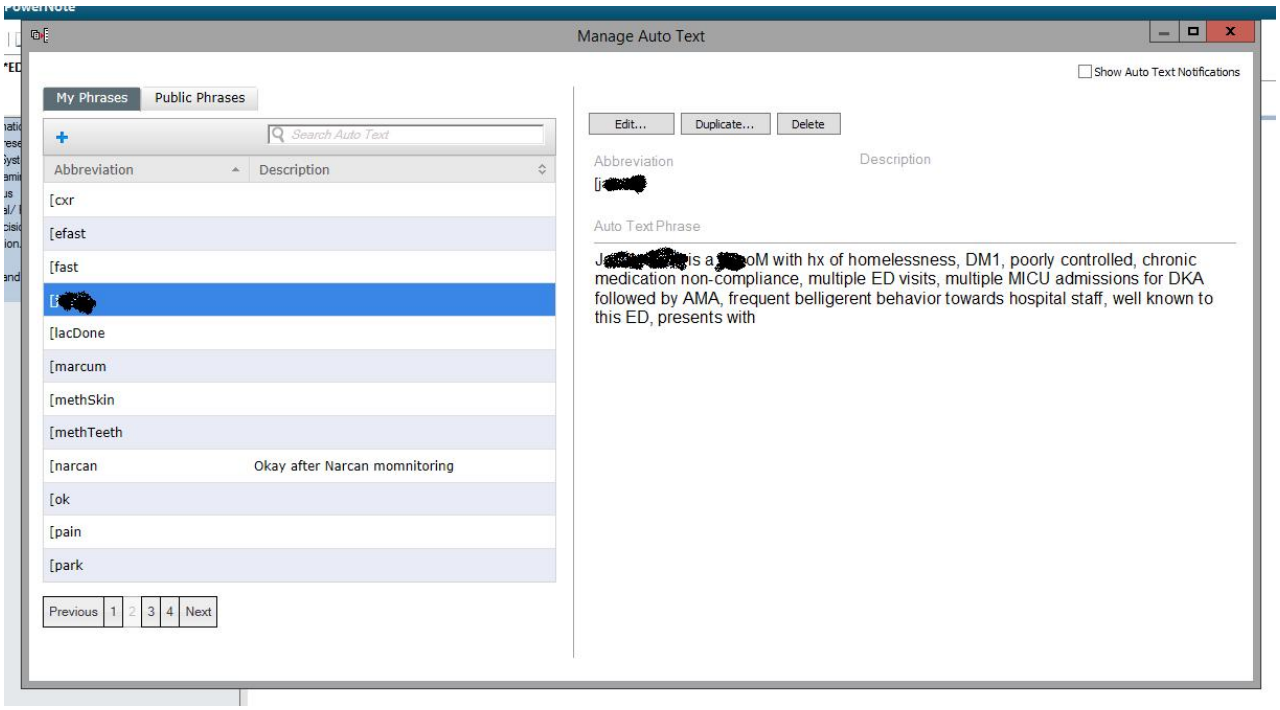




Cerner: Dot Phrases

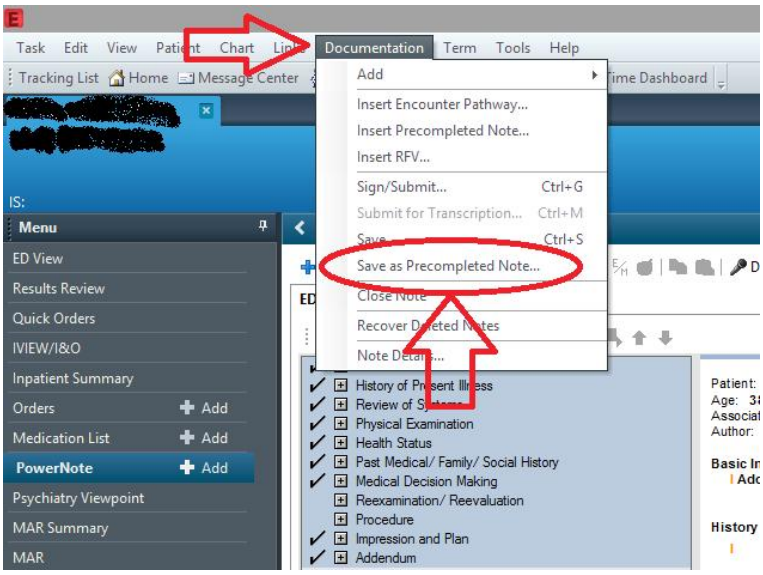
When you begin intern year, and are still learning about how to work up and disposition patients, you will spend more time thinking about how and what you need to document. As you get more comfortable and familiar with various dispos, you will find yourself charting similar things for certain patient types. Things like, every trauma patient will need to ambulate and tolerate PO before leaving, all drunk patient will need to demonstrate some level of clinical sobriety, etc. Once you settle on how you want to document those things, create a dot phrase. It will not only save you the time and effort to type or Dragon it, but it will also free up the mental energy of re-phrasing it every time, and reduce your overall cognitive load.

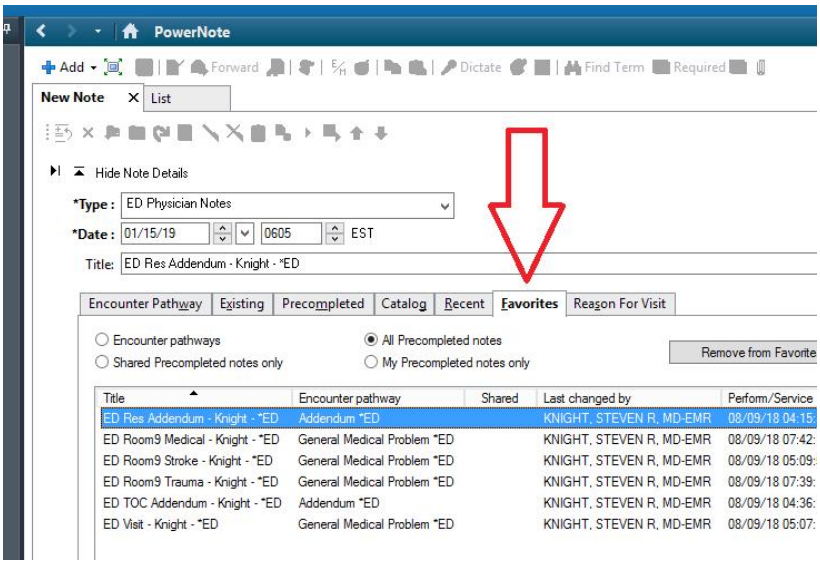




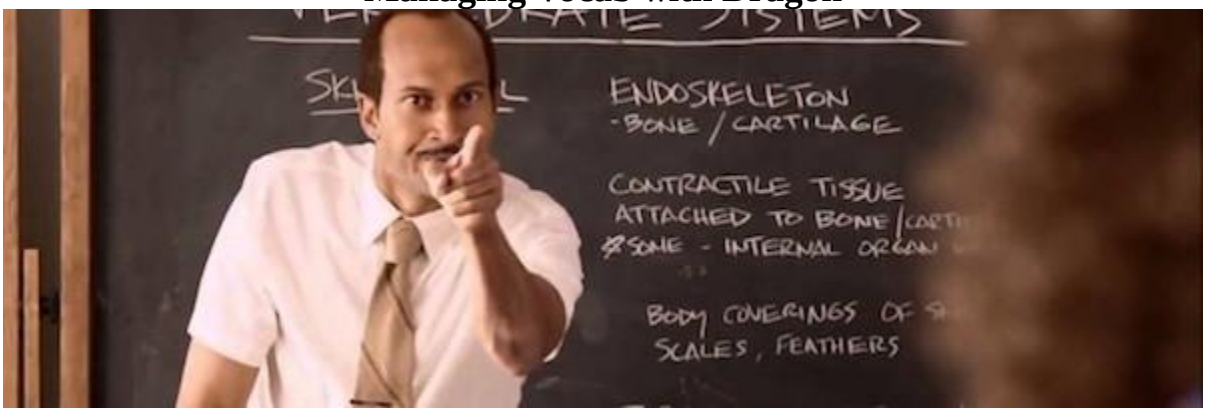
Cerner: Note Templates

So to me, this saved a ton of time navigating within the Cerner chart. You can save a number of note 'Templates', which can hold things like formatting, layout, font, positioning, things like that. Everybody will be a little bit different, but for me for example, my vision and posture sucks, so larger font is nice, my past med hx just goes in with my HPI, not it's own tab, and I prefer free text to click boxes. By saving all that in a note template, it saves me a ton of time opening or closing different subsections of my note, and overall note navigation is much more fluid.

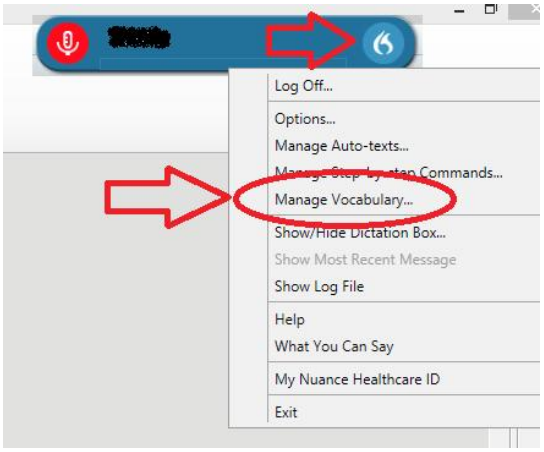


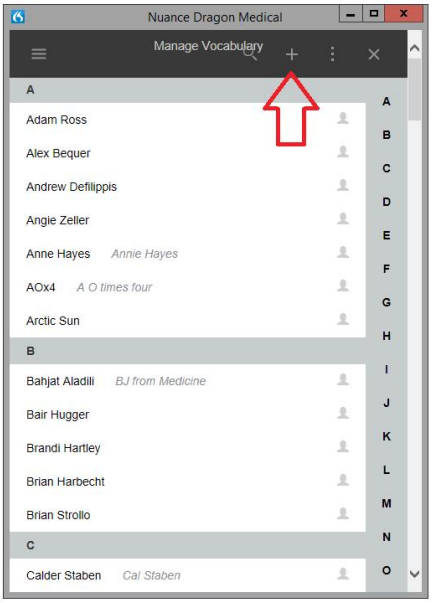


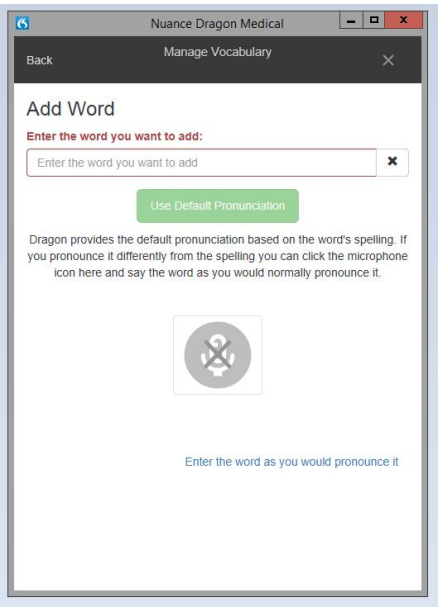
On Shift Dictation
Managing Vocab with Dragon

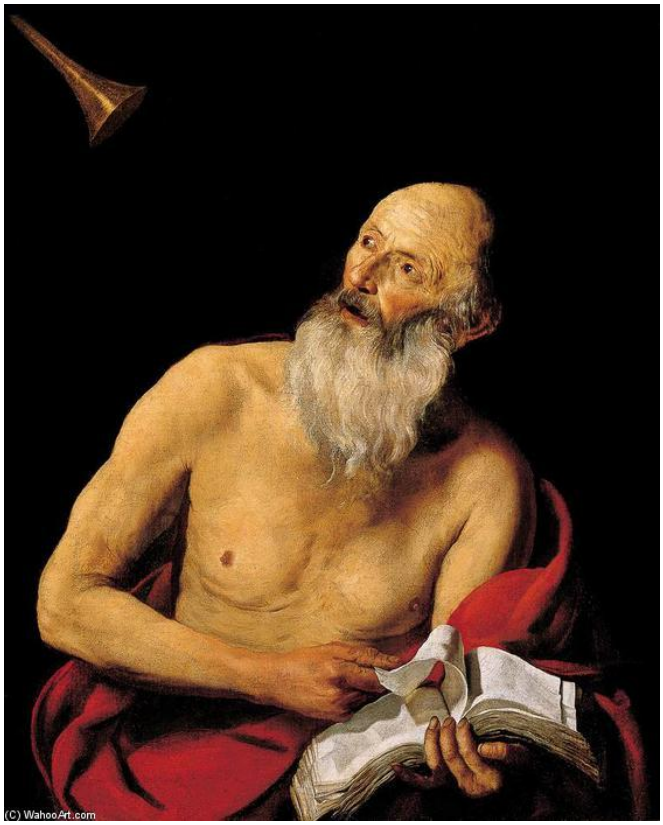


Take control of your Dragon vocabulary, and form it to the language you actually use. This was slightly easier on the previous version of Dragon, but still works fairly well on the new one (though is a little less user friendly). For instance, you can add words that aren't part of the default vocabulary, like UofL specific terms, or most especially, NAMES. A particular benefit to adding unique names is that not only can you use them fluidly while documenting, but you can ALSO simply drop an attending name into the 'supervising physician' box for order entry without having to type. You can also delete sound-alike words that keep popping up, that you never actually use.









Scribe Utilization

This is harder to describe, but maximizing your time at bedside to both interview the patient *and* dictate to your scribe has led to my best efficiency improvements throughout third year. When you take a history, you can both talk to the patient in everyday language, but sort of sprinkle in the buzzwords you want charted while you're repeating back, or as a quick aside to your scribe while you're doing a physical. Additionally, trying to think out loud about your physical exam in the room (when socially appropriate), will keep the scribe from having to ask you about it later, which again will reduce task switching. Also make sure they have the templates you like, especially for things like Room 9 documentation.