

Procedure Notes **for Resident Clinical Logs**

CPME 320, *Standards and Requirements for Approval of Podiatric Medicine and Surgery Residencies* requires that the "Procedure Note" (PN) in web-based clinical logging must support the chosen log category for ALL log entries and ALL categories.

In general, the Procedure Note:

- Must never be left blank
- Must describe what is being logged even if it seems redundant, as it must provide proof (or substantiate) that what was logged is in the correct logging category
- Must never *only say* "refer to Op Note" or "refer to EMR note," as that does not substantiate the logging category chosen
- Must be clear and we recommend it is concise

1. Biomechanical Examinations (BME), Category 7

- Procedure Note for a BME must have :
 1. a diagnosis (or complaint if dx not determined)
 2. a simple description of treatment provided.
- No need to state "biomechanical exam for..." The shorter the entry, the less the resident needs to enter and the less the program director needs to read when reviewing.
- No need to copy and paste the entire biomechanical exam into the procedure note.
- The diagnosis must be something a BME can be performed for:
 - onychomycosis, tinea pedis, diabetic and/or routine foot care visits and acute trauma generally are not appropriate diagnoses/complaints.
 - Corns or calluses may be appropriate, if treatment is aimed at the underlying pathology causing the corn/callus.
- Acceptable BME PN examples: "Dx – R plantar fasciitis. RX- stretching, inserts, injection, PT"
" C/o R heel pain. RX - stretching, inserts, injection, PT"

2. Surgery/Procedures, Categories 1 – 6

- Use the fewest words to describe the procedure effectively (e.g. Austin R)
- Common procedure names are sufficient (e.g. Austin, Lapidus, Dwyer, Cotton)
- If there is no common name, describe what procedure was performed (e.g. ORIF R bimall fx, ostectomy R dorsal talus, DFWO L 1st met, ostectomy R dorsal 2nd met base)
- Must list location if not inherent in name (cannot say "midfoot" must list specific bones)
- It is okay to add more detailed description of procedure, and/or fixation utilized to show diversity.

- It is strongly suggested that ALL external fixators are described (especially if there are pins in tibia/fibula) due to hospital privileging rules one may encounter after residency.
- When logging cases with multiple procedures, do not repetitively list ALL procedures done in the entire case for every procedure being logged. Instead, for each individual procedure logged, please only describe THAT specific procedure performed in that procedure note. This makes it easier to correlate procedures logged with procedure descriptors. Example:

2. Surgery/Procedures, Categories 1 – 6

Don't log this:

Logging Code

1. bunionectomy with distal metatarsal osteotomy
2. Central metatarsal osteotomy
3. Correction Hammertoe

Procedure Note

Austin, Weil 2nd, pipj arthrodesis,
Austin, Weil 2nd, pipj arthrodesis
Austin, Weil 2nd, pipj arthrodesis

Log this:

Logging Code

1. Bunioneomy with distal metatarsal osteotomy
2. Central metatarsal osteotomy
3. Correction Hammertoe

Procedure Note

Austin R
Weil 2nd R
pipj arthrodesis R 2nd toe

3. History and Physical Examinations (H&Ps), Category 8 and Medical and Surgical Specialties, Categories 9 and 10

- Procedure Note for an H+P must have :
 1. a diagnosis (or complaint if dx not determined)
 2. type of H+P (or similar descriptor for Category 9 or 10)
- H&P examples:
 - Admission H&P for gas gangrene right foot
 - ED H&P for SOB and CP
 - Pre-op H&P, Pes cavus - Cole procedure
 - Medicine H&P, Irritable Bowel vs Crohn's dz
- Do not log an H+P and a Category 9/10 for the same visit. Choose one or the other.
- Category 9 and 10 experiences must be logged to substantiate clinical experiences in non-podiatric rotations
- Category 9 and 10 examples:
 - EMG/NCV - neuritis vs radiculopathy
 - Interpreted ABI/PVR and Angiogram
 - Close reduced and splinted right forearm fx

4. Wound Care, Category 11

- Procedure Note should include:
 1. Type of wound (if known)
 2. Specific location including laterality.
 3. Level of debridement (fibrinous slough/Skin/sub)
- Debridement down to and including muscle /tendon *might* best be categorized elsewhere (cat 1,2,3,5) if performed in the operating room
- Debridement including bone *should* be logged in category 4.

- Wound care Procedure Note examples:

Cat 11.1: Sharp Excisional Debridement plantar R 1st mpj ulcer to subQ tissue.

Cat 11.2 Misonix Debridement wound dorsal L midfoot, application biologic dsb
(ok to list brand names of biologic)

Reminder: Only log one wound care procedure per case for all wound care (either 11.1, 11.2 or 11.3)
Allografts /Biologics belong in this category (not plastic surgery).