

DIPA

Describe. Interpret. Predict. Act.

You already reason about where your patient is heading. **Almost none of it reaches the chart.** DIPA is four questions that make that reasoning explicit, so the covering physician, the night nurse, and the record all know what you were thinking and what would change the plan.

D Describe What is happening with the patient now? Findings, objective data, change from baseline.	I Interpret What does it mean, and why is it happening? Diagnosis, etiology, acuity, severity, linkage.	P Predict What is the expected course, and what would say it is not going well? Trajectory, deterioration signals, escalation criteria.	A Act What are we doing, monitoring, and escalating? Treatment, reassessment, escalation plan, disposition.
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A prediction without a corresponding action is **not DIPA documentation**.

THE ONE RULE

Anticipated risk must be paired with the monitoring and escalation plan that answers it. They are one move, not two. Documented risk with no response is the weakest possible record. Risk paired with criteria is the record that defends your care.

WHAT IT LOOKS LIKE

DESCRIBE	T 39.1, HR 118, RR 28, BP 88/54, SpO ₂ 86% RA. RLL infiltrate. WBC 18.4, lactate 3.8, creatinine 2.0 from baseline 0.9.
INTERPRET	Sepsis due to community-acquired RLL pneumonia with hypotension and lactic acidosis. Acute hypoxic respiratory failure. AKI likely secondary to sepsis-associated hypotension.
PREDICT	At risk for progression to septic shock and worsening hypoxemia if hemodynamics, oxygen requirement, lactate, and mental status do not improve with resuscitation and antibiotics.
ACT	Fluids, cultures, ceftriaxone and azithromycin, O ₂ for SpO ₂ above 92%, serial lactate. Escalate to ICU for MAP < 65 > 30 min , lactate rising , O₂ > 6 L/min , or new confusion.

WHAT USUALLY HAPPENS

Service ▶ Discharge ▶ Coding ▶ Claim ▶ Denial ▶ Rework

WHAT DIPA SUPPORTS

Encounter ▶ Explicit reasoning ▶ Earlier recognition ▶ Timely action

WHY IT MATTERS TO YOU

- ▶ **Better handoffs.** The covering clinician inherits your reasoning, not just your findings.
- ▶ **Fewer retrospective queries.** Ambiguity resolved while you still remember the patient.
- ▶ **A defensible record.** Documented risk paired with escalation criteria is contemporaneous evidence you recognized it and planned for it.
- ▶ **Nothing new to buy.** Works in a smart phrase. Overlays SOAP, APSO, and assessment and plan.

WHERE IT APPLIES

Inpatient

Escalation criteria as observable conditions with thresholds

Ambulatory

Return precautions and ownership of every open loop

WHAT DIPA IS NOT

Not a coding checklist. Not an E/M leveling tool. Not an automated diagnosis engine. Not a deterioration detector. Not a replacement for your judgment.

Read the framework. Use it. Tell us where it breaks.

Four documents: the framework, an ambulatory companion, a pilot charter, and a vendor evaluation guide. Published openly for review and comment.

reveiqai.com/dipa.html

Matthew Ayinde, MBA, BSN, RN · Emergency nurse, clinical documentation integrity, AI workflow and prompt architecture · **Comments and corrections:** dipa@reveiqai.com

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