PROGRESS NOTES GUIDELINES

Progress notes are legal documents and form an essential part of providing care to a client and as a support worker and/or nurse you will be required to record the client's status or achievements each time you complete a shift.

Progress notes are important for documenting a client's movement towards their goals as identified in their Individual Support Plans / Care Plans and represent a record of events at the end of each shift. Other terms you might hear progress notes referred to as are daily notes, shift reports or communication notes.

When writing progress notes they should be based on tacts and observation and is a descript of what actually happened. This is called "**Objective writing**". When completing the progress notes at the end of your shift ask yourself what did you:

Hear?	Say?	See?	Do?

Objective writing is NOT influenced by personal feelings or opinions, and these should not be included in any progress notes. Here is an example of an objective progress note:

- ✓ *'At 3.30pm when I arrived on shift Marcella had just returned from a walk to the Albert Street Park and she was holding her right arm against her body. I noticed that she had a graze and bruise on her right arm. Marcella said a dog had jumped on her when she was sitting on the grass at the park. She said she had been frightened and that her arm was sore.'*

Subjective writing, which is based on or influenced by a person's point of view, emotions, assumptions, speculation, judgement, or interpretations, should not be used when completing progress notes. Here is an example of a subjective progress note:

- × *'Marcella must have bumped into something when she went on a walk to the Albert Street Park, as she has grazed skin and a bruise on her arm. She was holding her arm and looked unhappy'*

How do I get started writing progress notes?

Prior to starting your progress notes think about:

- Why you are writing the document
- Who will read it?
- What they will do with the information
- The clients progress towards goals identified in Individual Support Plans or Care Plans including actions taken, progress made, barriers identified.
- Any specific things that the other members of the client's team to know about.
- The order in which things happened (time frame)
- Highlights or significant details of the shift
- The client's level of participation or refusal of assistance
- The client's significant achievements and changes

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Dos and Don'ts of Writing Progress Notes

Do

- ✓ If not already written on the sheet write the clients full name on each page
- ✓ Record date and time of each new entry. Time should be in 24-hour time (i.e., 2300 for 11pm)
- ✓ Continue notes by clearly stating on the new page: i.e., 13/02/2018 (cont.)
- ✓ Write legibly. Print if your handwriting is not legible.
- ✓ Write concisely. Stick to essential information only
- ✓ Objectively describe type of day the client experienced (i.e., Jane had a comfortable day, no complaints of pain or client stayed in bed complaining of pain)
- ✓ Medication given (i.e., morning medication given as per Webster Pack)
- ✓ All observations of client and actions taken (i.e., catheter blockage with sediment in urine, reported immediately to Case Management or appropriate person and then record what instructions they provided)
- ✓ Record all community access visits
- ✓ Record all medical appointments (take file with you when visiting appointments)
- ✓ Record the names of people involved in conversations and activities
- ✓ Write your observations as you saw them in a factual manner (e.g., Jane was observed to be crying, head in hands)
- ✓ Be descriptive in your notes and describe what actually occurred or was said, tone used
- ✓ Be mindful of language used. Comment in a respectful and non-judgemental manner.
- ✓ Sign the progress note after each entry

Don't

- × Alter notes or use correction fluid. Incorrect entries should be corrected drawing a single straight line through the mistake and writing 'error' and initialling above the error.
- × Write a diagnosis if you are not qualified to make a diagnosis. I.e., Jane is suffering with anxiety. Instead write – Jane displays symptoms or signs consistent with anxiety, wringing hand, sweating.
- × Make assumptions. DO not use the word 'appeared'
- × Express your opinions or impressions
- × Include information such as "I said I would feed the pet at 830 but got distracted so feed it at 1030.
- × Use jargon. Ensure you understand and can clarify all language used
- × Use the following words: abnormal, abusive, impulsive, irrational, overwhelmed, resistant, suicidal, threatened, troubled, lazy, stubborn etc UNLESS they are accompanied with a clarification. For example, "I observed Jane to be highly anxious, biting nails, pacing around the room, pulling at hair, saying that she felt like her head would explode.