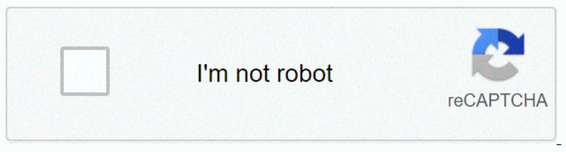

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Progress notes aged care template

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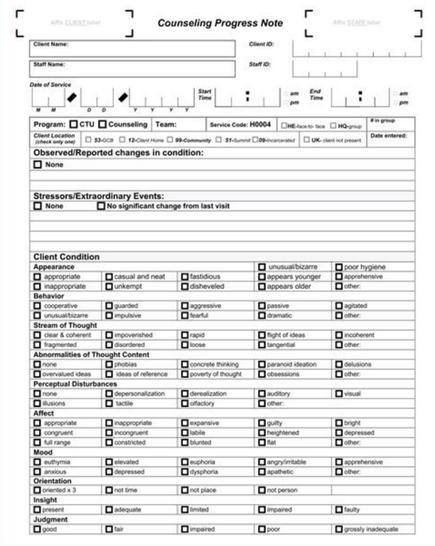


Counseling Progress Note

Client Name: | Client ID:
Staff Name: | Staff ID:
Date of Service | Start Time | End Time
Program: CTU Counseling | Team: | Service Code: H0004 | HE-face-to-face | HG-group
Client Location (check only one): 53-GCB | 12-Client Home | 99-Community | 51-Summit | 09-Incarcerated | UK- client not present
in group | Date entered:

Observed/Reported changes in condition:
None

Stressors/Extraordinary Events:
None | No significant change from last visit

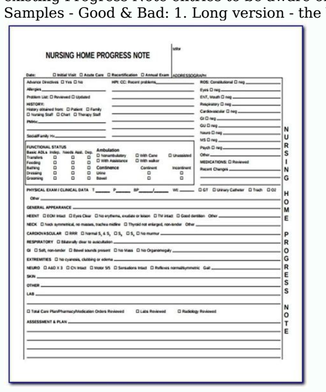
Client Condition

Appearance				
appropriate	casual and neat	fastidious	unusual/bizarre	poor hygiene
inappropriate	unkempt	disheveled	appears younger	apprehensive
			appears older	other:
Behavior				
cooperative	guarded	aggressive	passive	agitated
unusual/bizarre	impulsive	tearful	dramatic	other:
Stream of Thought				
clear & coherent	impoverished	rapid	flight of ideas	incoherent
fragmented	disordered	loose	tangential	other:
Abnormalities of Thought Content				
none	phobias	concrete thinking	paranoid ideation	delusions
overvalued ideas	ideas of reference	poverty of thought	obsessions	other:
Perceptual Disturbances				
none	depersonalization	derealization	auditory	visual
illusions	tactile	olfactory	other:	
Affect				
appropriate	inappropriate	expansive	guilty	bright
congruent	incongruent	labile	heightened	depressed
full range	constricted	blunted	flat	other:
Mood				
euthymia	elevated	euphoria	angry/irritable	apprehensive
anxious	depressed	dysphoria	apathetic	other:
Orientation				
oriented x 3	not time	not place	not person	
Insight				
present	adequate	limited	impaired	faulty
Judgment				
good	fair	impaired	poor	grossly inadequate

Progress Notes are brief narrative entries written to record negative and positive events relating to residents. They are also used to record situations regarded as irregular, and residents' response to lifestyle issues. Progress Notes are written to supplement care documentation so that the quality of care can be continuously improved. They enable staff to re-assess the needs of residents, make changes to their Social Profiles and seek appropriate interventions for Care Plans. What should be recorded as a Progress Note? Progress Notes can encompass many facets of residents' lives: Diminisghing interest in social activities Reactions from medications Sudden change in health Confrontations with peers Results of therapeutic interventions Change in behaviour Absconding Intrusive behaviour Poor participation in activities due to deteriorating health Errors How to record Progress Notes Progress Notes can be handwritten or typed. If you are lucky enough to work in a facility where Progress Notes are recorded electronically, you will find that Progress Notes are quick to access and easy to record, saving you valuable time. Be Objective and Brief To be effective, Progress Notes must be objective: you must report information that is measurable. You should record situations that you have witnessed or initiated.

Figure 1. Internal Medicine Template Hospital Progress Note at Lee Memorial Health Systems.

Subjective documentation is not recommended as it cannot be evaluated. Subjective entries are those which reflect your opinions or assumptions. It is also important to keep Progress Notes short; they should be a simplified version of what occured. Objective phrases are those based on observation and presented as facts. They should not be written based on prejudices or influenced by emotional outpour. However subjective words such as: eager, agitated, enraged, restless and so on, may be used in Progress Notes to describe your impression of the resident. Your description is of clinical significance to the RN or doctor. Always read through existing Progress Notes It is suggested that staff read existing Progress Note entries to be aware of changes and exceptions to medication, diet, occupational therapy, physio therapy, dentists, medical practitioners, behavior assessment, appointments, and recreation therapy. Integrated Progress Notes indicate continuity of care from a multidisciplinary team of health and care staff. 11 Progress Notes Samples - Good & Bad: 1. Long version - the WRONG way Staff were escorting Mrs Bow to the dining room when she saw Mrs Allen wearing a yellow cardigan. Mrs Bow started weeping, saying repeatedly: 'it is my cardigan'. She then insisted on going back to her room and refused to eat. Staff established that the cardigan had no name tag.



NURSING HOME PROGRESS NOTE

1. Short version - the RIGHT way Mrs Bow was visibly upset when she assumed Mrs Allen was wearing her cardigan, a fact that could not be verified by staff as there was no name tag. Mrs Bow declined lunch after the incident. 2. Long version - the WRONG way This evening I was passing by the dining room when I saw the RN administering medication to Mr Casals. However, as soon as the RN turned her back Mr Casals spit his tablets out into his hands and placed them quickly in his pocket. I went and found the RN to inform her. 2. Short version - the RIGHT way At lunch time I observed Mr Casals taking tablets from his mouth and placing them in his pockets. RN informed. 3. Long version - the WRONG way Sitting in the recreation room, Mr Tiller became very agitated and red in the face and used abusive language towards Mr Sims when he saw him walking away with his walker. Staff told Mr Sims that the walker did not belong to him and he returned it. 3. Short version - the RIGHT way Mr Tiller became distressed and used improper language when Mr Sims mistakenly took his walking aid.
He settled down after it was returned. 4. Long version - the WRONG way I escorted Mrs Jenny Ho to the toilet but when we got there it was occupied by Mr Gill. He stayed there too long and Jenny couldn't hold on anymore and wet herself. Staff took her back to her bedroom so she could change her clothes. What's wrong with this information?
"Stayed too long" - compared to what? When was a time limit set up to go to the toilet?
By whom? "Wet herself" - How do you know? Maybe Jenny has an 'UTI' (urinary tract infection). Maybe she drank too much liquid. How about this: 4. Short version - the RIGHT way Staff escorted Jenny Ho to toilet but she didn't make it. Jenny was escorted away to be attended to. 5. Long version - the WRONG way Ivy was waiting for her lunch when she started calling; "nurse, nurse". Lindy, sitting nearby showed Ivy her walking stick and shouted out that she would bash her over the head if she didn't shut up.
5. Short version - the RIGHT way Ivy called the nurse repeatedly at lunch. Lindy resented it and threatened Ivy with her walking stick using improper language. Staff attended to Ivy. 6.
Long version - the WRONG way Linda's name was placed on the list for the bus outing "Fish & Chips on the Bay" by her relatives. When we got there Linda wouldn't stay seated, walking away all the time without her walking stick. Staff had to be with her the whole time afraid she would fall and break a leg. The problem was that the other staff had to look after another 6 residents on their own. It was very hard and staff agreed that Linda should not come on bus trips anymore. 6. Short version - the RIGHT way Linda went on the bus trip but became non-compliant with her walking aid. One-to-one attention was necessary for safety reasons. Linda's relatives will be invited to join bus outings in the future.

SAMPLE: PSYCHIATRIC NURSE PROGRESS NOTE
Generously Provided By Angel Home Care Services, Inc. – Miami, FL

PATIENT DETAILS | DATE | EMPLOYEE
HOMEBOUND DUE TO:
SKILLED NURSING SERVICES
NURSING VISIT CODE
RV – ROUTINE VISIT
EV – EMERGENCY VISIT
OBSERVATIONS / MONITORING
PATIENT / FAMILY TEACHINGS
NUTRITION
THERAPY PROVIDED
ADR SUPERVISORY VISIT
SPECIFIC MEDICAL TREATMENTS / TEACHINGS
ASSESSMENT OF PROBLEMS AND RESPONSES:

7. Long version - the WRONG way This morning at the gardening activity John called Bill 'names' and wheeled himself towards him to hit him. Bill was furious and did the same waving a small shovel in the air threatening to 'kill' John. When staff asked what the problem was John said Bill had 'pinched' his shovel but Bill said John had taken all the planting pots and left him with none. Staff sat them on opposite ends of the table and kept an eye on them for the remainder of the session.

Detailed Progress Note

Client Name_____Appointment Date_____Time In _____
Modality: 90791 90834 90837 90839 90846 90847 Interactive Complexity (90785) Time Out: _____
DX_____ DX_____ ☐ No Show / Late Cancel Reason: _____ ☐ Charge
Members present: _____
Session Content:
☐ anger management ☐ develop support ☐ medication discussed
☐ assertiveness training ☐ encouragement ☐ obtained release
☐ behavior plan developed ☐ explore conflicts ☐ parent guidance/training
☐ communication problems identified ☐ explore motivation for behavior ☐ plan/progress reviewed
☐ conflict resolution ☐ identify/ regard feelings ☐ relaxation training
☐ reinforce maladaptive behavior ☐ identify family roles ☐ reviewed social activities
☐ regulate satisfactions ☐ limited part in group ☐ (cont.) management training
☐ DBT (ind) reviewed ☐ DBT skills training ☐ reinforcements given_____
☐ other
Primary Themes/Issues and Client Response: _____

CLINICIAN'S ASSESSMENT
Client's Behaviors: ☐ Cooperative ☐ Argumentative ☐ Defiant ☐ Hypoactive ☐ Impulsive
☐ Hyperactive ☐ Agitated ☐ Insensitive ☐ Tearful ☐ Physical Aggression ☐ Inattentive
☐ Isolated ☐ Hyper-verbal ☐ Withdrawn ☐ Defensive ☐ Appetite Change ☐ Guarded
☐ Sleep Disturbance ☐ Other _____
Client's Thought Process: ☐ Logical ☐ Congruent with Mood ☐ Obsessive ☐ Confused
☐ Disordered ☐ Delusions/ Hallucinations ☐ Tangential ☐ Disassociable
☐ Circumstantial ☐ Other_____
Client's Affect/Mood: ☐ Euthymic ☐ Congruent ☐ Angry ☐ Ambivalent ☐ Anxious
☐ Depressed ☐ Grandiose ☐ Jail ☐ Hopeless ☐ Flat
☐ Suicidal ☐ Worthless ☐ Labile ☐ Other_____
Risk Assessment: Suicidal/Homicidal Ideation ☐ YES ☐ NO Victim/Perpetrator of Abuse ☐ YES ☐ NO
Contracts for safety ☐ YES ☐ NO Alcohol_____ ☐ Denied Drug_____ ☐ Denied
Progress Towards Goals: ☐ Progress as expected ☐ Progress better than expected ☐ No Progress ☐ Maintained
PLAN: _____

7. Short version - the RIGHT way At the gardening session this morning staff had to separate John and Bill as they exchanged expletives and threatened each other. The reason for the altercation was not established. 8. Long version - the WRONG way This morning Denia asked staff to take her home because her mother was waiting for her. She was holding two shopping bags full of clothes and an umbrella. Staff tried to tell her that she should wait until her family came to take her but she wouldn't listen. She started to cry and walked the in the direction of the front door. She said her mother would be terribly worried if she didn't come home. Staff had to call for assistance to take her back to her room. 8.
Short version - the RIGHT way Denia was delusional and rather distressed this morning, crying and packing her clothes. Staff spent extra time with her to console and reassure her. 9. Long version - the WRONG way Martin was very difficult this afternoon asking staff to put more sugar in his coffee. Staff explained to him that three 'splenda' (artificial sugar) was what he usually took because he is a diabetic. He said he wanted more and shouted abuse at staff. Staff had to go and ask the RN for permission and the RN said staff could give him one more sugar. 9. Short version - the RIGHT way This afternoon Martin became enraged and used improper language with staff saying that his drink didn't have enough sugar.
Staff consulted the RN and Martin was given extra sugar. 10. Long version - the WRONG way This morning Jean was sitting on the table for craft when staff noticed that Irene came from behind and took Jean's handbag. Staff tried to rescue the handbag before Jean noticed it but it was too late; Jean called Irene a 'thief' and demanded her handbag back. Irene was persuaded to give back the handbag when staff presented her with another one. 10. Short version - the RIGHT way Irene behaved intrusively this morning by taking Jean's handbag.
Jean used inappropriate language but calm was restored when staff offered another handbag to Irene. 11. Long version - the WRONG way Myrtle was agitated and upset with the hairdresser because her name was not on the list for a hair-set. The hairdresser explained to Myrtle she had her hair set only fortnightly but Myrtle didn't want to hear it, she wanted her hair set. Myrtle was making a scene and staff had to remove her from the hair salon. Staff consulted the RN who suggested a phone call to Myrtle's family to ask for permission to have her hair set again. This was done and peace restored. 11.
Short version - the RIGHT way Myrtle was confused thinking her hair appointment was today. She became distressed and at the RN's suggestion Myrtle's family was consulted and she had her hair set which made her very happy. Need more examples? Related: 12 Tips for Writing Progress Notes Progress notes are created by caregivers at the end of

a shift. This guide includes valuable tips on how to write progress notes to a high professional standard for the Home Care industry. Find out more. Progress notes are a vital part of a care delivery framework and a must-have for any care delivery team.Progress notes reflect a client's movement towards their goals, as identified in their Individual Support Plans, and also represent a record of events on each shift or visit, and thereby serve as a communication tool for staff.By reading this guide, you can find out more about why progress notes are important, and what kind of information should be included in progress notes.
You will also pick up valuable tips on how to write progress notes to a high professional standard.What are Progress Notes in home care?Progress notes are documents created by support workers at the end of a shift and are an essential part of a Client Personal File. In progress notes, staff succinctly record details that document a client’s status and achievements. Progress notes are a tool for reflecting on a client’s movement towards their goals, as identified in their Individual Support Plans. They also represent a record of events on each shift or visit, and act as a communication tool for staff and families.As well as being used in home care, progress notes may be used in community care, group programs, sheltered accommodation, and nursing homes. Just like in home care, nursing progress notes are an essential record for improving the quality of care and support. They also function as a legal and medical record, and can be shared with both the patient or resident and their loved ones.Nursing progress notes can be updated in real-time or completed at the end of the nurse’s shift.
They should include details of a patient’s care, any changes in their condition or medication and any incidents. In aged care, progress notes help ensure older people receive consistent, high-quality care. They are a legal record that details the care the client receives, their health and any important changes. Day to day, they allow carers to communicate in-team about the client’s condition.Progress notes are particularly helpful when clients have memory loss, as they serve as a tool for communication between the client, their loved ones and carers.
Family and friends can receive regular updates about the client’s activities. Moreover, the contents of the progress notes can be used to navigate conversations without making the client feel uncomfortable about forgetting things.Why do we write Progress Notes?We record and file progress notes for the following reasons:Progress notes act as proof of service delivery.Progress notes constitute a legal record.Progress notes become part of a patient’s permanent legal record. Progress notes may be used in legal proceedings, audits and investigations.
They also provide a paper trail in case of conflict or difficult situations.It is mandatory to report incidents (and alleged incidents), either directly or via a supervisor, manager, specified person, or member of the provider’s key personnel.Reportable incidents and allegations include:InjuryAlleged abuse and/or neglect by a worker, another participant, a family member, another service provider, visitors, members of the community, etc.Unlawful sexual or physical contact or assault.Sexual misconduct.Unauthorised use of a restrictive practice.DeathProgress notes recorded in the ShiftCare app may be used as evidence.If you are unsure of whether to report an incident or allegation, report it! The relevant personnel will decide what (if any) action is needed.Progress notes link service to care plans and help in preparing client’s plan review:Progress notes link service and progress to the client’s overall plan, to client goals and to individual strategies. Information from progress notes can be used to write client progress reports, which usually need to be submitted every 12 months. These reports help aged care decision-makers with progress and care plan reviews, and these, in turn, help to guide the carers whose work it is to implement participant goals. Sharing InformationProgress notes can be used to share information between carers, families and coordinators (including team leaders and managers) so that all interested parties can keep abreast of changes in patient status, routines and needs.For in-home services, progress notes play a vital role in ensuring transparency of care between care teams, as well as for primary carers.Progress notes can act as handover notes for next shift staff.Here are some simple examples that demonstrate how sharing information recorded during care visits can be helpful:Sharing information between different carers:A carer working with a patient in the morning records in a progress note that the patient has not eaten their breakfast. The carer coming on shift with the same patient in the afternoon has access to that information, and can make absolutely sure that the patient eats lunch.Sharing information between care workers and families:A care worker goes out shopping with a dementia patient and records the experience, including what was purchased. Having read the notes, the patient’s family can use the information as a point of conversation. Without context, it may be hard for a dementia patient to remember the morning visit to the shop, and it could frustrate them when the topic is raised. Having read the progress note, a family member can pose a detailed question, such as: “How was shopping? I understand you bought new cushions, what colour are they?” This creates a more rewarding experience for both the patient and their family.How to write Progress NotesA progress note is by no means the entire record of the visit. It is simply a snapshot of what transpired, including the most significant factual information. If the carer is already familiar with the client’s routines and behaviour, the main point is to note any deviation from the client’s normal routines and patterns.Progress notes are partly generic in nature; for example, comments on a patient’s physical state and emotional wellbeing are likely to be appropriate whether the setting is mental health care, disability care, dementia care, or any kind of nursing context. Beyond this, progress notes should also relate to a client’s individual plan; to their individual goals and strategies.All progress notes must include:Your name.The date and time.Details of any reportable incidents or alleged incidents, including those involving peers or others, and including details of witnesses if there are any.Other types of information that it may be appropriate to record in progress notes, depending on the specific home care situation, include:Visits from health professionals.Changes emotional wellbeings.Carer interventions and assistance given.Changes in behaviour.Degree of participation in activities.Behaviour of concern (what happened before, during and after).Reactions to medications.Concerning changes in physical appearance.Dietary notes.Here are some important guidelines to consider when making progress notes:Progress notes should be recorded at the end of every shift.Progress notes can be written by hand or typed.Write down events in the order in which they happened.Include both positive and negative occurrences, and anything out of the ordinary.Record errors made by caregivers - even your own errors!.Keep in mind the goals in the client’s plan. You may wish to work from different progress notes templates for different patients.Write concisely, so that others can easily scan the information. At the same time;Notes need to include enough information that others can understand what happened.Where significant, state what occurred before, during and after and incident.Use plain language that any adult would be able to understand (even if they have no specialist knowledge, speak English as a second language, or have a learning disability).Consider using the STAR model to record information: Setting, Trigger, Action, Result.Be specific. For example: “At 3:45pm Jane’s temperature was 39 degrees”, not just, “Jane had a fever this afternoon”.Accurately describe the types of assistance given during each activity. Eg. Verbal cues, or hand-over-hand assistance.Write using the ‘active voice’ rather than ‘passive voice’. The active voice places the focus on the doer of the action:Active VoicePassive VoiceMr Ryan refused to eat breakfast.Breakfast was refused by Mr Ryan.Staff helped Mrs Bradford to get dressed.Mrs Bradford was helped to get dressed by the staff.Carer found Ms Smith on the bedroom floor.Ms Smith was found on the bedroom floor.The nurse changed Mrs Clair’s sheets.Mrs Clair’s sheets were changed by the nurseInformation should be objective, not subjective. What did you see / hear / say / do? Record concrete, factual information. Do not include your opinions about the facts. (For more help with how to write progress notes objectively, see this NDS workbookHere are examples of objective and subjective writing, taken from the same workbook:Example of objective writing:“At 3.30 pm Marcella returned from a walk to Albert Street Park and she was holding her right arm against her body. 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.”Example of subjective writing:“Marcella must have bumped into something when she went on a walk to Albert Street Park, as she has grazed skin and a bruise on her arm. She was holding her arm and looked unhappy.”How is ShiftCare revolutionizing Progress Notes?Recording & Sharing On-going Progress:ShiftCare’s Progress Notes provide a daily account of each client, their illness (if any), and developments within their care, for all those who visit that client. Carers can use the app to communicate with one another, making it easier to assess whether a client’s health is getting worse, better or remaining the same. ShiftCare’s App includes a ‘speech-to-text’ technology which allows carers to quickly and easily record progress notes. The voice notes are automatically transformed into text to be submitted.Smooth & Immediate Transfer of Handover Notes to Following Shift Carer:The progress notes feature in the ShiftCare app provides a way of recording relevant, on-going, and active problems. By sharing these notes between teams, via the app, problems are communicated carer to carer in real-time, with no need for a handover of physical documents or folders.ShiftCare keeps records of progress notes for audit purposes:Care coordinators are responsible for auditing progress notes, ensuring that carers have visited clients at the correct times, and checking for any concerns or problems that haven’t been reported to the office. With the ShiftCare app, all this information is available in one place. Records are stored securely on our server, and there is no risk of information loss. theft or damage. Records are stored securely on our server, and there is no risk of information loss, theft or damage.Progress notes in disability, aged care and nursing aren’t just a legal requirement. They’re also a tool that will help your business run smoother by ensuring good communication between team members. Most importantly, progress notes enable you to provide high standards of care and monitor clients’ needs.To discover how ShiftCare’s progress notes feature can revolutionise your business, sign up for a free trial.