



The **Richmond** Fellowship
OF NEW SOUTH WALES

Client Progress Notes Guidelines

Purpose

Progress notes are an essential part of a Client Personal File where staff and clients succinctly record details to document the client's status or achievements whilst a client of RFNSW. Progress notes are a tool for reflecting on 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, a communication tool for staff. It is essential that progress notes reflect the strengths and recovery-focused elements of RFNSW's work with clients, to enable the story of their journey through the program to emerge.

All progress notes should include a succinct summary on the following:

- A client's progress towards goals identified in Individual Support Plans (actions taken, progress made, barriers identified).
- Level of support provided by staff (i.e. increasing or decreasing, verbal prompts or physical support, staff completing tasks for client).
- The client's level of participation in and partnership with the RFNSW service.
- The clients significant achievements and changes.

- Appointments attended
- The outcome of Service Coordination Meetings.
- All communication with other services involved with client (including phone calls, emails, faxes, face-to-face contact). All attempts to contact other services need to be recorded.
- Referrals made.
- Group activity participation (provided by the RFNSW service and externally).
- Any information given to clients
- Any follow-up required.
- All informed consent decisions (e.g. *Client provided consent for staff to discuss low mood with mental health case manager*).

Important Points Regarding Progress Notes

- Personal client file notes including progress notes are legal documents. Progress notes can also be subpoenaed at any time and staff can be cross-examined in a court regarding the contents of progress notes.
- Remember all client data in the personal client file including progress notes is to be kept confidential.
- All client personal files must be kept in a secure location and accessed only by authorised RFNSW staff.
- Ensure all sections of the file, are kept in a clean and tidy condition in the approved RFNSW order. Progress notes must be kept in a chronological order.*

* This point will be obsolete within CIMS

- An entry into the progress notes must be recorded during every contact or each shift (morning, evening and night) depending on the program.
 - For residential services: following night shift, where there has been no contact, a progress note must be made stating "*Nothing to Report on Night Shift*".
- All progress notes should be read at the start of each shift, in order that support workers have a clear indication of the client's current situation, what support the client will require, or what follow-up activities need to occur during the shift.
- All progress notes should be written with reference to the previous entry. For example if morning shift notes refer to client's low mood, the subsequent notes on evening shift must comment on mood (i.e. improvements, ongoing concerns, management of concerns).
- Progress notes must reflect the client's communication, behaviour accurately and fairly.
- When writing progress notes workers must be mindful of how someone reading the notes will perceive the entries regarding the client and the RFNSW service provision.
- Client's have the right to request to read their own file notes.

Do's and Don'ts of Writing Progress Notes

Do

- ✓ Write the Client's full name on each page.*

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- ✓ Record date and time of every new entry in the date column. Time should be in 24 hour time (i.e. 2300 for 11pm).*
- ✓ Make entries as close to the time of client contact as possible. (Contemporaneous)
- ✓ Identify late entries as such. Record the date and time that the late entry is being made in the date column, and the date of the contact in the notes section (i.e. *written in retrospect for 13/02/2011*).
- ✓ Continue notes by clearly stating on the new page: i.e. *13/02/2011 (cont)* in the date column on the following page.*
- ✓ Write entries in black biro pen (not felt tip pens).*
- ✓ Write legibly. Print if your handwriting is not legible.*
- ✓ Ensure that the spelling, grammar and punctuation is correct.*
- ✓ Use approved abbreviations only.
- ✓ Write concisely. Stick to essential information. Notes can be written using headings and dot points to assist with brevity.
- ✓ Record the names of people involved in conversations, activities or incidents.
- ✓ Use Action plans to enhance communication and reduce the risk of follow-up being lost in verbal handover. Examples of sub-headings that can be used include:
 - Action Plan: for any tasks to be followed up on as numbered items
 - *eg. Phone Call to be made to...*
 - *Discussion regarding... to take place...*
 - *Support to appointment...".*

- Outcome:
 - *Phone call to ... talked about...*
 - *2. Discussion had re: the following:*
 - *a). Jane's achievements through the week...*
 - *b). Jane's ongoing low mood...*
 - *3) Observations of...".*
- ✓ Make reference to related notes written in previously. For example, (see entry on 3/2/11) you may comment on the client's mood (observations/discussion re: mood, support provided, how client managed).
 - ✓ Use descriptions: objective (when staff report on things that they observe) or subjective (when staff report on what the client says or feels). Observations are reasonably undisputable facts of action, appearance or statement.
 - ✓ 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, describe what was actually said, tone used, body language etc, i.e. "*Mary was shouting loudly in a high pitched angry way, swearing and saying I was useless. Throughout her shouting she was staring wide eyed and pointing at me*".
 - ✓ Be mindful of language used. Comment in a respectful and non-judgemental manner, using strengths and recovery-focused language.
 - ✓ Sign the progress note after each entry, The worker making the entry must provide their signature, designation and printed name [i.e. *Samantha Jones* (S Jones MHRW)].*

Don't

- ✗ Alter notes or use correction fluid. Incorrect entries should be corrected by drawing a single straight line through the mistake and writing 'error' and initialling above the error. The correct word or statement should then follow.*

- I.e. Joan stated that she ~~had taken medication~~ error^{JF} did not take her medication today.
- ✘ Leave any spaces between entries. Use a line to fill in the blank area.*
- ✘ Transcribe doses of medication in progress notes (As per RFNSW policy) i.e. do not write the milligrams next to the medication name, write instead *"name of staff observed 1 ½ tablets of Lithium taken"*).
- ✘ Write a diagnosis if you are not qualified to make a diagnosis. I.e. Jane's is suffering with anxiety. Write symptoms instead (e.g. *"Jane displays symptoms or signs consistent with anxiety, wringing hands, sweating, Joan reports loss of appetite, ..."*)
- ✘ Use the following words: abnormal, abusive, anxious, impulsive, irrational, overwhelmed, resistant, suicidal, threatened, troubled, delusional, dangerous, disturbed, hysterical, immature, uncooperative, lazy, unfit, stubborn etc. UNLESS they are accompanied with a clarification. I.e. *"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 re: subjective feelings of anxiety..."*.
- ✘ Use jargon. Ensure you understand and can clarify all language used (i.e. do not use clinical terminology unless you are confident of the meaning and can explain the meaning).
- ✘ Make assumptions. Do not use the word 'appeared'.
- ✘ Express your opinions or impressions UNLESS you state that it is your opinion.
- ✘ include information such as *"I said then she said"* and *"I went to their home at 8.30am but no-one was up so I went back to the office and will return to check in at the home in 40 mins"*

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