Progress Notes Procedure

Progress Notes are required to document evidence of face-to-face contact with the patient, information about the patient and/or contact with someone regarding the patient. They are also used in conjunction with the Treatment Plan to assess progress made in completing treatment plan goals and to modify treatment plan goals if necessary.

In order to insure that quality care is being provided, it is essential that an entry be made in the patient's file after every therapeutic session with the patient, after a contact with someone regarding the patient or after a patient has not shown for their appointment.

Progress note entries for face-to-face sessions (Individual, Family or Group) must be documented in a DAP format. Collateral notes, or contacts with others regarding the patient, do not need to be in DAP form, but must include date, time, person's involved, and state the content of the contact.

Progress notes must be entered in the IA-WITS system. See the Encounter Note Entry Procedure on how to enter Encounter Notes and the Misc Note Entry Procedure on how to enter a Miscellaneous notes into the patient's IA-WITS file.

No Show, Cancel, and Rescheduled Sessions:

These notes are entered into a Misc. Note. We need to have clear documentation when a patient cancels, no shows, or reschedules an appointment. If there is any gap in services there needs to be an explanation in the file about what the issue is. If the patient has attendance problems, that needs to be addressed with the patient and documented in the file with an explanation.

Collateral Notes:

These notes are entered into a Misc. Note. Uses for this would be when trying to reach a patient, you receive a call or voice mail from the patient, you send a letter to the patient, when you speak to someone regarding the patient's treatment involvement (Mental Health Worker, DHS working, Probation Officer, etc), treatment plan/treatment review, etc. It is very important that any time you speak to someone about a patient's case that there is clear documentation in the file on what has been communicated (please also make sure there is a valid release when speaking with another person about the patient).

Individual Sessions:

These types of notes are entered into an Encounter Note. The progress note is to be completed within the same business day as the session was provided. Whenever possible, the entry should be made immediately following the contact.

There are three different types of Individual Notes in a patient file; Outpatient Individual or Crisis, Outpatient Family and Residential.

Outpatient Individual/Crisis Notes:

The note needs to contain the following information in the narrative:

- Type of Service provided (i.e. – Individual or Crisis)
- The DAP portion of the note (what took place, how it pertains to the treatment plan, the patient's level of participation, counselor input, and plan following each contact)
- The counselor/service providers name and title

Outpatient Family Notes:

The note needs to contain the following information in the narrative:

- The DAP portion of the note (what took place, how it pertains to the treatment plan, the client's level of participation, counselor input, and plan following each contact.)
- The counselor/service providers name and title

Residential Notes:

The note needs to contain the following information in the narrative:

- Length of the contact in fifteen (15) minute increments (i.e. 15, 30, 45, 60, etc.) due to the fact that most Residential Individual notes are posted into a pre-entered encounter note for the residential day of service
- The DAP portion of the note (what took place, how it pertains to the treatment plan, the client's level of participation, counselor' input, and plan following each contact)
- The counselor/service provider's name and title

To provide uniformity in how these entries are made, the following format will be used for all individual, family and crisis session contacts. The notes will be divided into three sections:

(D) Description: The subjective and/or objective. Subjective is usually recordings of the patient's statements noted in quotation marks. This includes what the patient says about themselves, others and their environment. Subjective data is usually placed first to ensure the patient's point of view is taken into consideration at the onset. Objective is the counselor's observations of the patient's behavior and appearance. For example, "The patient did not make eye contact during the session. Broke into tears." There needs to be an indication whether the patient has remained substance free. The counselor should also record their interaction with the patient describing what took place and how it pertains to the patient's goals.

(A) Assessment: This is the interpretive section of the progress note. It includes the counselor's analysis of and conclusion about the current situation and is based upon the subjective and objective data. This is the counselor's clinical judgment of what has been said and done based upon what they have seen or heard. What does the data mean, suggest, or give evidence of?

(P) Plan: Is based on the subjective, objective and assessment of data gathered. It answers the question "What happens next? What is indicated in the way of follow-up? Immediately? At the next session? Before the next session? For the next several sessions? Change in the Treatment Plan? Discharge? Transfer? Graduation? Referral? If there is a change in the Treatment plan it should be clearly stated in the DAP note of the treatment session. The date and time of the next session should be noted.

Group Notes:

This type of note is entered into an Encounter Note. All treatment group notes must be in DAP format. Information recorded must include a summary of what happened in group. The Group note is to be completed within the same business day as the group was held (or last group held in a work week for Residential/Halfway House group notes.) There are 2 types of Group notes:

Residential/Halfway House Group Summaries:

The note needs to be done in a weekly summary. This can be any 7 day period but it needs to be consistent within your component (i.e. - with the week starting on a Monday and ending on a Sunday or starting on a Thursday and ending on a Wednesday). The note will contain the following in the narrative:

- Name of Group(s)
- Dates of group and the facilitator who did the group
- DAP note
- Name and title of staff person who wrote the note

Outpatient Group Notes:

These will be done in one note for each group. The note shall contain the following in the narrative:

- Name of group
- DAP note (the patient’s actions and the facilitator’s actions)
- Facilitator name and title

The Group DAP Format is:

(D) DESCRIPTION: The subjective and/or objective. Subjective includes what the patient says about themselves, others, their life and/or environment. The patient/patient’s statements if quoted should in quotation marks. If patient/patient’s

statements are lengthy, carefully paraphrase the statement. Subjective data is generally placed first to ensure the patient's point of view is taken into consideration. There may be a statement regarding patient/patient using or remaining substance free. Objective date is factual observations, usually about the patient/patient's behavior and/or appearance; for example, "She did not make eye contact or He broke into tears". Objective data may include information such as dirty alcohol/drug screenings or information received from other sources. (What did the patient/patient say or do in group). It is also important to state what the facilitator of the group did or how he/she interacted with the patient. (This part of the note clearly states F.8 – Progress Note Procedure 3 "What happened in group").

(A) ASSESSMENT: This is the interpretive section of the group note. It includes the facilitator's analysis of and conclusion about the current situation and is based upon the subjective and objective data. This is the facilitator's clinical judgment of what has been said and/or done based upon what was seen or heard. What does the data mean, suggest or give evidence of? (Why did it happen?).

(P) PLAN: Is based upon the data and assessment. It answers the question "What happens next? What is indicated in the way of follow-up? At the next session? Before the next session? Changes in the Treatment Plan. Is there a new problem? Changes in the type, level or location of treatment. Completion or Discharge from treatment is scheduled. Date and time of the next session.

Group Note DAP Example:

D: Molly reports that she is clean and sober. Molly shared resentments she has toward her dad because he is an alcoholic and was abusive to her mom. Molly also related to feeling abandoned because her mom always had different men, has been married ten times, mom is bipolar and dependent on men, but recognized that mom's mental health issues impacted her actions. I encouraged her to identify the positives things she received from her marriages such as her children who she loves dearly.

A: Molly was very active in group today. She is beginning to address her anger toward her dad and mom. While understanding that mom has some mental health issue that impacted her decisions. She is beginning to trust that it is okay to share her painful experiences within the group. She is also looking at the positives things in her life.

P: Molly will attend group on August 30th at 3:00 PM. She will be encouraged to share her feelings and explore what she can do to move beyond the pain of her past.