PROGRESS NOTES

Documentation is an essential component of effective communication. Nursing progress notes help ensure residents receive high quality care. Progress notes are an ongoing record of a resident's health status, treatments, and service delivery. Progress notes are used to communicate important information about a resident to medical, clinical, and allied health staff and provide proof of service delivery.

Progress notes are **legal documents** which can be brought before a court of law, requested by the coroner and by the Aged Care Quality and Safety Commission.

Progress notes should be:

- clear
- legible
- concise
- progressive
- accurate
- factual
- relevant
- completed in a timely manner

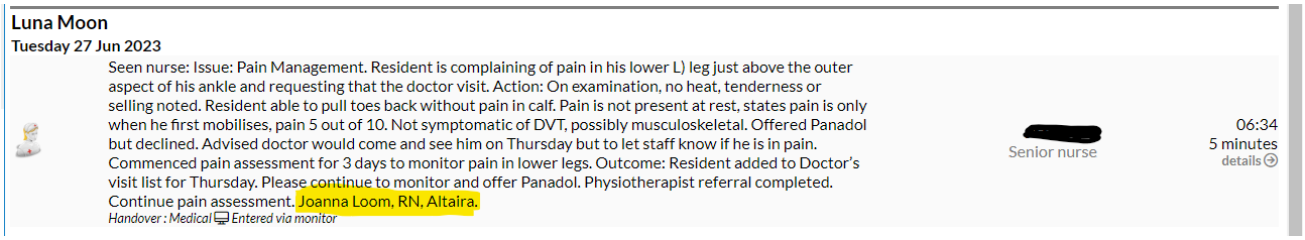
Progress notes should be written using **Issue**, **Action**, and **Outcome**.

ISSUE:	Reason for progress note? (e.g., pain management, falls management) What has the resident said? (e.g., resident complaining of pain in his leg and asking for the doctor)
ACTION:	Assessment of the situation: - What did you observe? - What is the situation? - Details of any incident - Include clinical assessments, eg vital signs, pain levels - Any risks or complications - Changes in behaviour, well-being, or emotional state Actions taken: - What actions were taken? - Were there changes made to the care provided? - What interventions were there to minimise risk, complication, and changes in behaviour?
OUTCOME:	What is your plan/recommendations? - What follow up is required? - Instruction for future care or reassessments which may be required. What was the outcome?

REFER TO EXAMPLE PROGRESS NOTE BELOW

EXAMPLE PROGRESS NOTE:

Issue: Pain Management - Resident is complaining of pain in his lower L) leg just above the outer aspect of his ankle and requesting that the doctor visit. **Action:** On examination, no heat, tenderness or selling noted. Resident able to pull toes back without pain in calf. Pain is not present at rest, states pain is only when he first mobilises, pain 5 out of 10. Not symptomatic of DVT, possibly musculoskeletal. Offered Panadol but declined. Advised doctor would come and see him on Thursday but to let staff know if he is in pain. Commenced pain assessment for 3 days to monitor pain in lower legs. **Outcome:** Resident added to Doctor's visit list for Thursday. Please continue to monitor and offer Panadol. Physiotherapist referral completed. Continue pain assessment.



POINTS TO REMEMBER:

- Progress notes should be **signed off** with your name, designation, and agency name. This can be done using electronic systems (see example progress note).
- Always check that you are writing in the relevant resident's progress notes.
- Documentation is important to prove your actions - **If it isn't documented, then it wasn't performed.**
- If you are writing retrospectively, you must include the date and time of the event within the progress note.
- Use full words where possible and only use recognised industry abbreviations and acronyms.
- Do not use assumptions, judgmental language, or red flag terminology.
    - Just because a person looks unhappy doesn't mean they are sad, or just because a person is staggering doesn't mean that they are drunk.
    - When you state that someone is being aggressive or agitated you are making a judgement call on their behaviour. When documenting someone's behaviour – just say what someone did and your response to that, for example, the resident was waving his hands around in the air and I maintained a safe distance until he stopped waving his hands.
    - Red flag terms are words or phrases that are sensational in nature. Like he was banging his hands on the table, and he is going to **attack me**, or he was laying on the floor with the sensor beam on top of him and he was trying to use the sensor beam as a **weapon**.
- When documenting **always stick to the facts and only the facts**.