

Project AsPIRE Progress Notes Guide

Progress notes are notes that are part of the regular file maintained at NYU CSAAH (electronically and hard copies). The following kinds of information go in a progress note (further guidelines and examples appear below).

- counseling session start and stop times,
- medication prescription and monitoring
- the modalities and frequencies of intervention activities
- results of clinical tests, and
- any summary of the following items:
 - Diagnosis,
 - functional status,
 - symptoms,
 - prognosis, and
 - progress to date.

Who Is The Audience?

In any writing project, the first and most important question is “who is the audience?” Throughout the writing process, one must step back occasionally and hear what is written using the ears of the potential audience(s). Often, as with the notes we’ll be discussing here, there will be multiple audiences and you must keep each of them in mind while writing. Here is a listing, intended to be in order of likelihood, of those who will see and use progress notes:

- You, the CHW, will look back at the notes as needed in the course of treatment.
- The client or patient may want to look at the notes and the contents of the file and has this right under HIPAA regulations
- Another AsPIRE CHW who becomes assigned to your case in your absence (i.e. sickness/vacation) will need to access notes and contribute to notes during the period he/she manages the case.
- Lead CHW –will review your progress notes each week to ensure completeness
- Clinical Supervisor–will review and sign off on your progress notes each week to ensure proper follow up was done and documented appropriately. This will take place when you present the case at weekly clinical supervision meetings
- Project Director, Project Coordinator will review to retrieve data for analysis
- Principal Investigator may review progress notes periodically –also to help him provide appropriate clinical advice especially for challenging cases

These various potential readers of your notes create different concerns and expectations for the contents of your notes. What will be most useful to you in the future may very well not be what you would want your client to read and a note that works for you and your client may not be something you’d want in the hands of an attorney hostile to your client’s interests. You won’t know as you write which audience will see your notes, but need to keep in mind that you are writing for these different readers.

This is not, in practice a difficult task.

- First, keep in mind that your task in a progress note is to **document that reasonable work occurred toward the goal of helping the client** with her or his issues.
- Your note can **be brief**; to the extent that you can relate that day's work to treatment issues and methods you've defined previously in a treatment plan, the easier your documentation will be.
- Keep track of **significant events**—changes in medications, life events, names of important people that come up—that you will want to be able to easily reference in the future.
- As noted in the formats described below, include brief assessments of the **client's status** and **progress** as appropriate and remind yourself of **plans** you have for future sessions (homework assignments, topics to follow up on).
- Leave longer thoughts, queries and reflections for your assessment notes. The advantage that your assessment notes give is that you can record any hypotheses, personal reactions, doubts, possible interpretations, supervisory recommendations, etc. in a form that will be maximally useful for you.

Where Are Progress Notes Kept?

In general, progress notes will be typed immediately following a session and will be kept in reverse chronological order in the client's file locked in the appropriate drawer at NYU CSAAH. The client's file may be removed only for purposes of adding and reviewing notes and replaced when you are finished. If an occasion arises in which you want to remove the file from CSAAH, you need permission of the Project Director and need to put a check-out card where the file was so that staff know it is out. If you are in possession of a file, you are responsible for maintaining its confidentiality—keep it in your possession or keep it in a secure place.

A note regarding assessment files is in order at this point. You may be keeping assessment materials with you for scoring and writing outside the CSAAH. The safest way to preserve confidentiality and secure the file is to keep name identification out of the file until you finalize it in a report. Electronic progress notes will be saved with the file name as the UID and participant's initials (i.e. 3019MS). Then secure the original printed file and all materials at CSAAH.

Styles Of Progress Notes

The following are some suggestions for the content of progress notes:

- Use the standard Progress Note form to provide the basic information about who was seen when by whom, for how long and for what purpose.
- The note may be brief but should include a description of the major events or topics discussed, specific interventions used, your observations and assessment of the client's status, and any plans you may have for the future.
- It is not necessary that these notes be extensive. In fact, in future practice when time is of the essence, brevity and capturing the essence of the treatment in a session will be necessary. Two examples of structured systems for progress note writing are listed briefly below with references to more complete descriptions.

The preferred format for notes at the Clinic uses the acronym DAP (Description, Assessment and Plan). Baird (2002) suggests a similar format and his thoughts on clinical documentation are useful. In a typical

individual counseling session, a client may bring up two or three therapy-significant events or issues or describe the activity of carrying out a homework assignment. Each may be briefly documented in the DAP format.

Description:

- provides information as to who was involved, where, and when a significant event occurred.
- It could also be a description of an issue of personal importance discussed by the client and how they experienced the event.
- A description could also be the way a client carried out an assignment and the difficulties or success they experienced.
- We recommend that clinician behavior be woven into description.
- Description also includes what you did after listening and observing and reflecting on what the client brought to the session.
- This may be an interpretation offered, a clarification, information given, a homework assignment, a challenge to narrow thinking about an issue, formal problem solving around the event, empathetic/supportive behavior on your part, functional analysis of a situation, a normalizing comment, or whatever is appropriate from the therapeutic conceptualization you are using.
- If the situation is a serious one involving detailed assessment of danger or legal issues, you would document what you did in whatever detail is necessary to show that you attended to the issues involved.

Assessment

- is your understanding of what the event means if you know.
- Baird recommends thinking about how the event or behavior relates to precipitating factors, to previous behavior, to other events in the client's life, to the treatment plan.
- The important part of this aspect of your thinking and writing is your reflection on the events in the client's life in terms of treatment.
- Assessment may also record your observations about the client's physical or emotional state and such factors as severity of symptoms, riskiness of behavior, dangerousness, suicidality and so forth

Treatment Plan

- is your plan for future treatment.
- Baird notes that this may be as brief as "Scheduled for next Wed".
- If you give homework assignments or want to note topics to follow up on or actions to take before the next session, they can be entered here as reminders.

Please refer to attached ASPIRE Progress Note Template

Suggested Readings

Baird, B. N. (2004) *The Internship, Practicum, and Field Placement Handbook: A Guide for the Helping Professions* (4th ed.). Prentice Hall
Cameron, S. & turtle-song, i. (2002) Learning to write case notes using the SOAP format. *Journal of Counseling & Development*, 80, 286-292.
Wiger, Donald E. (1999) *The Clinical Documentation Sourcebook: A Comprehensive Collection of Mental Health Practice Forms, Handouts, and Records* (2nd ed.). Wiley.
Zuckerman, E. L. (2005) *Clinician's Thesaurus: The Guide to Conducting Interviews and Writing Psychological Reports* (6th ed.). Guilford Press.