



## MONTANA STATE HOSPITAL POLICY AND PROCEDURE

### DOCUMENTATION IN PROGRESS NOTES

**Effective Date:** November 28, 2017

**Policy:** HI-05

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- I. PURPOSE:** To provide guidelines for the entry of progress notes into the patient record.
- II. POLICY:** Progress notes will be regularly entered into patient records in order to provide chronological documentation of the patient's clinical course. Procedures for entering progress notes will meet all requirements of state and federal statutes and regulations.
  - A. Progress notes are recorded by the clinical staff involved in active treatment modalities. The notes contain recommendations for revisions in the treatment plan as indicated, and precise assessments of the patient's progress in accordance with the original or revised treatment plan
  - B. Progress Note frequency is determined by the condition of the patient, but notes are to be recorded at least weekly for the first eight weeks and at least once a month thereafter and when any significant events or changes occur in the course of the patient's treatment. Progress note frequency for patient transfers between units during the eight-week period following admission will continue weekly until the eight-week period is complete. Progress notes for patient transfers after the initial eight-week period will occur at least monthly. In the event a transfer is from a non-certified unit to a certified unit, notes are to be recorded at least weekly for the first eight weeks and monthly thereafter. On MSH Mental Health Group Homes progress note frequency will be at least every three months.
  - C. Staff will be trained in standard documentation practices. Refer to MSH Policy HI-03, *Charting – Rules to Observe*.
  - D. Rules for proper entry of information into the medical record must be observed.
  - E. Progress Notes are currently hard copy, but as Montana State Hospital transitions from a paper medical record to an electronic health record (EHR) the media and location used to capture documentation will reflect this change as electronic forms are developed, approved, and authorized by administration.
- III. DEFINITIONS:**
  - A. *Progress Note* – component of a patient's clinical record maintained chronologically and containing documentation of treatment provided to the patient, the patient's

response to treatment, significant events, and other information pertinent to the patient's clinical course.

- B. *Authenticate* – to establish authorship by written or electronic signature consisting of the staff person's name and professional title.
- C. *Attest* – the act of applying an e-signature to the content, showing authorship, approval of, and legal responsibility for the content.

#### IV. RESPONSIBILITIES:

- A. *Clinical Staff* – to make progress note entries regarding their respective fields of expertise that accurately reflect all treatment provided to a patient, the patient's response to treatment, changes in the treatment plan, discharge plans, and significant events occurring during the course of hospitalization as applicable.
- B. *Licensed Independent Practitioner* – to make progress note entries accurately reflecting all treatment provided to a patient, the patient's response to treatment changes in the treatment plan, discharge plans, and significant events occurring during the course of hospitalization. In addition, the Licensed Independent Practitioner must enter documentation in the clinical record that provides the rationale for each prescription ordered, an evaluation of the patient's response to medication, and the rationale for medication changes.

#### V. PROCEDURE:

- A. All staff members will record progress notes on the "Progress Notes" form in the patient's chart or in the EHR Progress Note when implemented as the legal media for documentation collection.

All progress note entries involving subjective interpretation of the patient's progress are supplemented with a description of the actual behavior observed. As a guideline, progress notes should be made immediately after a treatment or rehabilitation service is delivered and include:

1. identification of the service provided;
2. length of the session;
3. a description of the patient's response to the service, including behavior and/or verbal statements;
4. an assessment of the patient's progress, lack of progress, and/or needs; and
5. plans or strategies for the delivery of further therapy or rehabilitation services.
6. Licensed Independent Practitioners need to document the rationale for orders written including medications and treatments.
7. All entries must be signed dated, and timed. Progress notes that are entered in the EHR must be authenticated and attested to with an e-signature which captures the author, the date, and the time.

- B. Psychology Staff will record progress notes on “Psychological Progress Notes”. Notes not pertaining to Psychological Services will be recorded on “Progress Notes” form or the EHR progress note when implemented.
- C. Rehabilitation Therapy Department Staff will record progress notes in the EHR under “Service Notes”, “Mental Health Service Note”, or “Rehabilitation Aide Progress Notes” forms. Notes directly related to the treatment plan will be printed, signed and dated, and filed in the education and therapy section of the patient chart, other service notes will remain in the EHR service note.
- D. Licensed Independent Practitioners working in the Medical Clinic will document findings and recommended treatment on the Medical Consult Physician Notes located in the consults section of the medical record.
- E. RNs will record physical health assessments on the Nursing Physical Health Assessment form located in the Nursing Assessment section.
- F. Licensed Independent Practitioners and RNs will document information regarding use of restraint and seclusion on the appropriate Restraint and Seclusion Order and Progress Note form located under the Physicians Order section.
- G. All requirements set forth in M.C.A. §: 53-21-162 Establishment of Patient Treatment Plans and M.C.A. § 53-21-165 Records to be maintained relating to documentation and charting must be followed. These requirements include:
  - 1. a summary of each significant contact by a professional person with the patient;
  - 2. documentation of the implementation of the treatment plan;
  - 3. documentation of all treatment provided to the patient;
  - 4. chronological documentation of the patient’s clinical course;
  - 5. descriptions of any changes in the patient’s condition;
  - 6. a detailed summary of any extraordinary incident in the facility involving the patient, to be entered by a staff member noting that the staff member has personal knowledge of the incident or specifying any other source of information. The summary of the incident must be initialed within 24 hours by a professional person.
- H. Specific components of the patient’s treatment plan should be referenced when writing weekly and monthly progress notes. This helps demonstrate the correlation between the progress note entry and the patient’s treatment plan and the outcome of treatment and any observation or information that could form a basis for altering the patient’s course of treatment.
- I. When it is not practical to make an entry each time a treatment or rehabilitation service is delivered, information about a series of treatment services may be summarized into a single progress note. Such a note should include an identification

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of the service provided; a listing of the dates that the service was delivered; a summary of the patient's response to the service, including and/or verbal statements; an assessment of the patient's progress, lack of progress, and/or needs; and the plan for the delivery of future therapy or rehabilitation services.

- J. When making a notation of an unusual or noteworthy event in the progress notes, the following information should be recorded:
1. a description of the incident;
  2. an assessment of whether the event represents a significant departure from the patient's typical behavior;
  3. an assessment, if possible of the reason for the event's occurrence;
  4. staff response;
  5. recommendations for future action to be taken (e.g., interventions to be used; changes to the patient's treatment plan or changes in medication; alterations to the patient's environment); and
  6. clear reference to the date and time that the incident occurred.
- VI. REFERENCES:** M.C.A §: 53-21-162, 53-21-163 and 53-21-165; CMS 42 CFR Part 482 conditions of participation for hospital, Subpart E – 482.61, (d) special medical record requirements for psychiatric hospitals.
- VII. COLLABORATED WITH:** Director of Health Information; Director of Clinical Services; Director of Nursing; and Medical Director.
- VIII. RESCISSIONS:** HI-05, Documentation in Progress Notes dated May 6, 2015; HI-05, *Documentation in Progress Notes* dated January 26, 2011; HI-05, *Documentation in Progress Notes* dated August 2, 2007; HI-05, *Documentation in Progress Notes* dated September 1, 2002; HI-05, *Documentation in Progress Notes* dated March 14, 2001; HOPP HI-05, *Documentation in Progress Notes* issued February 14, 2000.
- IX. DISTRIBUTION:** All hospital policy manuals
- X. ANNUAL REVIEW AND AUTHORIZATION:** This policy is subject to annual review and authorization for use by either the Administrator or the Medical Director with written documentation of the review per ARM § 37-106-330.
- XI. FOLLOW-UP RESPONSIBILITY:** Director of Health Information
- XII. ATTACHMENTS:** None

Signatures:

Jay Pottenger  
Hospital Administrator

Thomas Gray, MD  
Medical Director